IV. PROVIDER UTILIZATION

A. Overview

The Surveillance and Utilization Review (SUR) business function develops profiles of health care delivery and utilization patterns of providers and members that are based on user-defined parameters and other guidelines. Analyzing and comparing providers and members to their peer groups can detect aberrant practices. Appropriate action, such as recoupment, education, or prepayment review, is initiated to address the findings.

SUR procedures have been developed and defined to effectively utilize the retrospective reporting system. These procedures provide a consistent approach to the review and analysis of Indiana Health Coverage Programs (IHCP) data within the context of specific state regulations and policies.

The SUR department contributes to research and analysis activities performed by the Medical Policy (MP) department through postpayment review claims analysis, audits, and analyses associated with provider and member files. The levels of reviews are designed to flow logically from identification of providers and members with potential problems to initiation of corrective actions.

The purpose of these reviews is to perform utilization review activities that evaluate medical services for their appropriateness, reasonableness, and necessity; to determine if services are consistent with medical guidelines; to verify billed services; to identify and initiate recovery of refund accounts due, if applicable; and to educate the provider regarding identified problems.

The results of the review are documented in writing and are included in the off-site review procedures. Following presentation of the case to the Medical Director and determination of the final review recommendations for provider reviews, the case report is logged and referred to the Indiana Medicaid Fraud Control Unit (MFCU). The MFCU, which operates under the authority of the Indiana Attorney General's Office, reviews the recommendations before the SUR department takes any action. This procedure has been established to protect the confidentiality of any MFCU investigation.

1. Non-Hospital Reviews

   The non-hospital review team reviews utilization and billing practices of providers in non-hospital practice settings. This unit conducts audits of physicians, DME providers, chiropractors, transportation providers, and other provider types.

   Cases are generated from a variety of sources, including federal and state agencies, internal IHCP operational areas, members, community or anonymous sources, and the Provider and Member Concerns Line. In addition, providers are

identified through a number of statistical analysis methodologies. After processing, there are several types of recommendations that may be made, such as a medical record request for desk review, on-site review, provider education, recoupment, or placement of the provider on prepayment review. After implementation of the recommendation, the provider may appeal any determination except prepayment review. The SUR department performs a follow-up review after six to twelve months to determine if compliance has been maintained.

2. Hospital Reviews

   The hospital review team conducts reviews of acute care hospitals and psychiatric hospitals to evaluate and objectively document the patterns of health care provision and utilization. These reviews encompass both the inpatient and outpatient hospital settings. The results of the reviews assist in the identification and correction of pattern problems for acute care and psychiatric hospitals, and assist the Indiana Family and Social Services Administration (IFSSA) in the development of clear and consistent medical policy.

3. Program Integrity

   The Program Integrity team investigates and refers members and providers identified as potentially abusing services reimbursed by IHCP. Program Integrity receives referrals concerning providers and members through the Provider and Member Concerns Line, the Office of Medicaid Policy and Planning (OMPP), and the Medical Policy (MP) and Prior Authorization (PA) departments. Information gathered from referrals is logged into the SURS case tracking database. Research of claim history is conducted through Indiana*AIM* to determine type and volume of alleged abuse. Program Integrity coordinates efforts with MFCU, state, county, and local law enforcement agencies, and initiates referrals to the SUR management staff for potential case assignment.

B. Provider Selection for Review

Statistical analyses, algorithms, and neural network strategies provide significant contributions to the identification of providers for audit. These methods work synergistically to recognize patterns of fraud and abuse, and each method serves as a cross-validation for the other. A neural network is a computer algorithm that makes statistical forecasts. These computer models use historical payment patterns, by provider, to compute predicted payments. Individual providers are flagged if they exhibit payment patterns that are significantly variant from their predicted values. Using this system, neural networks work to identify variant providers, and drill-down analysis is used to uncover trends in provider utilization. This data discovery process uses structured query language (SQL) computing techniques to unveil hidden trends and variances in payment data and display the characteristics of individual provider activity. The use of neural networks for utilization pattern recognition represents state-of-the-art technology, and greatly enhances the traditional methods provided by the control files.

Algorithms from MedStat's extensive fraud and abuse detection library have been selected to identify problem providers specific to Indiana's utilization patterns.

The control files also serve as triggers to measure utilization volume by provider, and both supporting techniques provide contributing evidence of variant practice patterns. The use of these two adjunct methodologies ensure that those providers that are flagged for variance by neural network models have significant utilization to warrant a thorough drill-down, or claim specific, analysis and subsequent audit.

C. Referrals

All provider and member inquiries or complaints received are investigated to determine what actions must be taken. Issues are investigated and resolved in a timely manner.

1. Integrity of Referrals

   Reviewing Referrals (Investigation Procedure)

   a. Providers will be identified for possible investigation from various sources including the following.

      - Member Explanation of Medical Benefit (EOMB) feedback **(SUC – 63)**
      - Referrals from anonymous and non-anonymous members
      - Referrals from anonymous and non-anonymous providers
      - Medical Policy studies and/or investigations that highlight a suspected provider, provider type, or specific billing practice
      - SUR generated referrals
      - Referrals from the Prior Authorization department
      - Spin-off referrals from other investigations or reviews
      - Referrals from state agencies or contractors
      - Referrals from law enforcement agencies
      - Referrals from media sources
      - Projects identified through coordination with the National Association of SURS Officials (NASO).

   b. The SUR staff member receiving the call completes a referral report and forwards the completed report to Program Integrity Specialist. An example of the SUR Referral Report is included in **EXHIBIT IV – 1**. Information obtained on the report includes the following.

      - Date the call was received
      - Name, address, and phone number of the caller
      - Caller's relationship to the subject, if applicable
      - Nature of complaint

- Detailed information explaining the complaint or inquiry
- Name of person taking the call

c. The referral is prioritized by the nature of the complaint and an extensive analysis is conducted, which may include the following.

- A review of member and provider information through the Indiana*AIM* system.
- A review of claim history and payment information.
- Contacting the source of the allegation for further information.
- Conducting provider or member interviews.
- A review of the medical records and or other medical documentation.
- Consulting with appropriate IHCP personnel.
- Consulting with OMPP.
- A review of past practices identified through previous SUR referrals or reviews.

d. If the allegations of the referral are substantiated through the program integrity review, a referral is made to the appropriate entity for further investigation and appropriate action.

The SUR Director, through coordination with the Program Integrity Specialist, will accept leads, follow through, and investigate if necessary, all allegations of fraud and abuse regardless of the source. The Director will work with the MFCU, the Claims Processing Contractor, and any other State and Federal agencies to determine proper action to be taken. The Program Integrity Specialist will prepare and maintain detailed reports of all field investigations and forward to the SUR Director for approval. The SUR Director will forward the case to OMPP for review, as appropriate.

D. Balanced Billing

The SUR Department receives many complaints from enrolled members who have been billed for services that the he or she believe should have been paid by IHCP. The IHCP provider agreement, which all enrolled providers have signed, requires providers accept the IHCP reimbursement as payment in full and prohibits providers from billing the member for any portion of the provider's charge that is not reimbursed by IHCP. However, in some situations it is permissible to bill an enrolled member for services not covered by IHCP.

When a SUR staff member receives a complaint regarding balance billing, the following steps are taken to assist in achieving a resolution.

1. The member is asked if they have made an attempt to contact the provider. If the member has not, they are instructed to do so. If the member has attempted unsuccessfully to resolve the bill on his or her own, the complaint is logged in the

SURS database. The SUR Reviewer that received the complaint then initiates a review of the complaint. If it is determined the provider is inappropriately billing the member for a covered service, SUR will contact the provider and inform them of the state laws governing billing IHCP members. This may occur by a telephone contact with the provider or by sending the balance billing template letter. An example of the balanced billing template letter is included in **EXHIBIT IV – 2.**

2. Eligibility must be verified. If the member was ineligible on the date of service, no further steps need to be taken by SUR. The member is informed that the bill was valid and the member is responsible for payment. If the member was eligible on the date of service, a review of the claim history in the Indiana*AIM* system is completed. A claim submitted by a provider is considered proof the provider was given the member's IHCP information and may not bill the member (unless the service is not covered).

3. If the review determines are that the service billed was not covered by IHCP, SUR will request the provider submit documentation which substantiates the member was made aware the service was not covered by IHCP. The documentation must support the member being aware they would be responsible for fees associated with the service rendered.

4. If a balance billing letter is sent, the provider is encouraged to send a response outlining the results of the internal review of the member's account. If no reponse is received, the case is considered resolved unless further contacts are made by the member or provider to the SUR department.

5. If the provider is contacted via telephone, the justification or reason for billing the member is discussed. The SUR Reviewer informs the provider of Indiana Administrative Code 405 IAC 1-1-3(i), which states, "A Medicaid provider shall not collect from a Medicaid recipient or from the family of the Medicaid reciepient any portion of his charge for a Medicaid covered service which is not reimbursed by the Indiana Medicaid program, except for copayment and any patient liability payment as authorized by law." The provider must then follow up by mailing or faxing documentation to demonstrate the provider met the criteria outlined in the IHCP Provider Manual allowing providers to bill members.

6. If the provider contends the member was appropriately billed for services, all supporting documentation must be submitted for SUR review.

7. If the determination by SUR is the member was appropriately billed for services, the member is contacted via telephone or letter to inform them of their responsibility for the charges. A copy of this finding is also sent to the provider to confirm the appropriateness of their billing.

8. If the determination by SUR is that the provider billed the member in error, the provider is contacted via telephone or letter to inform them of the finding. A copy of the findings is also provided to the member, upon request, to assist the member in resolving any further claim disputes.

9. If program integrity identifies a pattern of a provider inappropriately billing IHCP members, an educational letter is sent to the provider. If the provider continues to inappropriately bill members, or other billing deficiences are identified when researching a balance billing complaint, a referral for SUR audit is initiated and forwarded to the appropriate SUR Supervisor.

EXHIBIT IV – 1
PROGRAM INTEGRITY REFERRAL REPORT

Record: 1274824715 **Referral**

Date of Call: 9/25/02 **Operator:** 67 Blank Reviewer

Type Code:	**Service Class:**	**Complaint Type:**
15 Provider	Physician	Charges for services not provided

Reviewed By Integrity Specialist:

Review Date: 9/26/02 **Specialist Initials:** RC

Investigation Opened:
Referred 10/15/02 **Referred** MFCU

Caller Information

Name: Doe, John
Street 101 Smith Road
City: Anywhere **State:** IN **Zip:** 46140
Phone: (317) 000-0000 **County:** Hancock
CallerMedNum 100999000999

Complaint Against

Name Bob Brown, MD
Address 555 North Street
City: Anywhere **State:** IN **Zip:**46253
Medicaid #: 200999000

Provider Specialty: 316 Family Practitioner

Comments

REASON OF CALL: 9/25/02 11:49:52 AM Caller states that Dr. Brown has been billing for services she has not received. Caller received an EOMB for charges and services not rendered.

EXHIBIT IV – 1
PROGRAM INTEGRITY REFERRAL REPORT (Continued)

RESPONSE TO CALL: 9/25/02 11:50:38 AM Caller informed that a referral would be sent to Program Integrity for review of this physician's billing practices.

09/26/02 Provider reviewed in Indiana*AIM* system, and a sample of members were taken from the time frame of July 1-31, 2002. A review of 10 members and their claim history was printed and manually generated EOB's were mailed to all 10 members to determine if they received the services that were billed for.

10/15/02 Three of the EOB's were returned postage marked 'no forwarding address. The remaining seven were returned and reviewed. Of the seven, four members state they did not receive one or more of the services listed. The three remaining members state the services billed for were received.

Due to the fact that five members have stated services which were billed for were not received, a referral will be made to the Indiana Medicaid Fraud Control Unit with all pertinent confidential information attached.--rc

Resolution
Program Integrity considers this matter closed.--rc

Health Care Excel – Friday, September 27, 2002 Page 2 of 2

EXHIBIT IV – 2
BALANCED BILLING PROVIDER LETTER

Date

General Hospital
Attn: Supervisor, Insurance Billing Department
P.O. Box 55555
Anytown, IN 99999

Re: IHCP Member: Jane Smith
IHCP Member's Number: 9999999999
IHCP Member's date of birth: 07/20/1957

Dear IHCP Provider:

This letter is regarding an inquiry that was made to Health Care Excel in reference to the above-named Indiana Health Coverage Programs (IHCP) member who received a bill for services that were rendered by your facility. The member is being billed for dates of service during the month of September 2000. A review of the claim history for this member shows that no claims were submitted by your facility.

Under 45 CFR 164.506, a covered entity may disclose or release Protected Health Information without the individuals authorization, for treatment, payment and health care operation activities. According to 45 CFR 164.501, "health care operations" include conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs.

Federal and state regulations prohibit providers from charging any IHCP member, or the family of a member for any amount not paid due to a reimbursement determination by the IHCP. See Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15; Indiana Administrative Code, Title 405, Article 1, Rule 1, Section 3(i). Further, you have agreed to comply with these regulations under paragraph (17) of the IHCP Provider Agreement that you signed when you agreed to become an enrolled provider. That provision states that you have agreed as follows.

> "To accept as payment in full the amounts determined by Indiana Family and Social Services Administration or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients). Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law."
>
> **If the member is being billed in accordance with IHCP policy, this matter can be resolved by providing an explanation, along with any applicable supporting documentation, for the billing action. If the IHCP member was billed in error, immediate action must be taken to cease billing the IHCP member. The provider**

EXHIBIT IV – 2
BALANCED BILLING PROVIDER LETTER (Continued)

must take any and all corrective measures necessary to resolve the issue. These may include, but are not limited to: promptly discontinuing to bill the member and adjusting the member's account; retrieval of the account from the collection agency and correction to the IHCP member's credit report; or refunding of any payments previously made by the member for the incorrect billing.

A copy of this letter is being sent to the IHCP member who made the inquiry with our office. We are requesting that you appoint a qualified representative of your office or facility to work with the member in resolving this issue. Within ten days of the date of this letter, please provide a written explanation, addressed to my attention at the address below, that sets forth how you have resolved this matter.

Health Care Excel
Attn: Program Integrity
2629 Waterfront Parkway East Drive, Suite 200
Post Office Box 53380
Indianapolis, IN 46253-0380

Failure to respond to this letter or to resolve this matter may result in a referral to the appropriate state agency for further action, which could include termination of your provider agreement.

The Office of Medicaid Policy and Planning appreciates and values your participation in the Indiana Health Coverage Programs. If you have any questions regarding this matter, do not hesitate to contact me at (317) 347-4500, extension 246, or toll-free at 1-800-216-5938. Please mention referral number 123 when calling.

Sincerely,

Program Integrity Specialist
Health Care Excel
Indiana Health Coverage Programs

c: IHCP Member

EXHIBIT IV – 3
PROGRAM INTEGRITY REQUEST FOR RECORDS FROM PROVIDER

Date

Dr. John Smith DDS
123 Main Street
Anytown, IN 99999
Fax No: 555-555-5555

Re: Jane Smith
Member Medicaid Number: 9999999999
Date of Birth: 04/27/1981

Dear IHCP Provider:

The Indiana Health Coverage Programs (IHCP) is reviewing services utilized by the above-named member. In order to conduct a thorough review, it is necessary for Program Integrity to receive a copy of the dental record (excluding x-rays) for this IHCP member.

As an agent for Indiana Family and Social Service Administration (IFSSA) Health Care Excel is authorized to request medical records. As a condition of enrollment, a provider agrees to release information about IHCP members only to the IFSSA or its agent, free of charge. According to the IHCP Provider Manual,

> "Records maintained by providers are to be openly and fully disclosed and produced to the IFSSA, ISDH, or authorized representative upon reasonable notice and request. Such notice and request may be made in person, in writing, or by telephone."

Under 45 CFR 164.506, a covered entity may disclose or release Protected Health Information without the individuals authorization, for treatment, payment and health care operation activities. According to 45 CFR 164.501, "health care operations' include conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs.

Please mail the requested information to the above address, attention Program Integrity, or you may fax to (317) 347-4535. Your assistance in this matter is greatly appreciated. If you have any concerns or questions, please call me directly at (317) 347-4500 ext. 246.

Sincerely,

Program Integrity Specialist
Surveillance and Utilization Review
Indiana Health Coverage Programs

EXHIBIT IV – 4
COVER LETTER TO OMPP– RESPONSE TO LEGISLATIVE INQUIRY

Date

Director Program Operations-Acute Care
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
402 W. Washington Street, Room W382
Indianapolis, IN 46204-2739

RE: SUGGESTED RESPONSE TO
Our Tracking ID: H99999999
Your Tracking ID: I9999999
Provider Name: General Hospital
Provider Number: 99999999

Dear:

Attached is our response to the correspondence that was forwarded to the Office of Medicaid Policy and Planning.

Please let me know if you need any additional information or assistance with regard to this matter.

Respectively submitted,

Director, Surveillance and Utilization Review

c: HCE Program Director

E. Provider Audit Process

1. Case Assignment
   A case assignment may be initiated from any of the sources noted in Section IV – B Provider Selection for Review. The following steps are followed when a case assignment is determined to be appropriate by SUR management staff.

   a. The SUR Supervisor enters the case into the SURS database.
   b. The SUR Supervisor assigns the case to a SUR Reviewer for completion of an off-site desk review.
   c. A notification of assignment is sent to the SUR Reviewer via electronic mail from the SURS database.
   d. The SUR Supervisor gives all information leading to the assignment of the case to the SUR Reviewer. This may include information from data queries, ranking reports, or referral information.

2. Case Prioritization
   When Program Integrity refers a case to SUR for review, a priority of green, yellow or red, is assigned with green being the highest priority. The case prioritization was designed to ensure that cases with the greatest potential impact to the IHCP are investigated in the shortest possible time frame. Caseloads are worked in the order of the priority. Management may change priority levels upon additional review of the case. The criteria used to assign priorities is explained in detail in **EXHIBIT IV – 5**.

3. Off-site Desk Review

   The SUR Reviewer will complete an off-site desk review of the assigned provider to determine whether full SUR case development is appropriate. A recommendation is made based on the review.

   a. A provider case file (hard copy) is created and maintained for each provider selected for review. The file will include the provider name and SURS database tracking number on the label. See Section XII for file contents and organization.
   b. The SUR Reviewer begins research for recommendation determination by gathering information from several sources.
      (1) If the provider has a previous review, the case file is located and reviewed. This may require ordering the case file from Recall, the off-site storage facility.
      (2) The SURS telephone call log is reviewed for relevant provider information. Reports from calls regarding the provider are printed and included in the case file.

c. Select an audit time frame for review. The audit time frame chosen may coincide with dates mentioned in the referral or with the SUR-3300QO Exception Ranking Report.

d. The following steps are utilized to order reports to facilitate the off-site review process. Begin ordering and reviewing provider reports from CO-MAND.

   (1) CO-MAND (Computer Output-Management Archiving and Network Distribution) contains information that displays the peer group(s) in which each provider is active, the number of providers in each peer group, and whether the provider is enrolled as an individual or group. It also displays a list of providers that except in descending weight order per category of service and contains summaries of all providers meeting activity minimums.

EXHIBIT IV – 5
CASE PRIORITY

Program Integrity will assign cases a priority of Green, Yellow, or Red based on the following criteria. Timelines for completion of the review are tied to the applicable case priority. Supervisor approval is required to change the priority level of case assignments.

GREEN PRIORITY (HIGHEST-LEVEL)					
Staff Member	PI Staff	SUR Reviewer	SUR Supervisor	SUR Reviewer	SUR Reviewer
Action	**PI Referral**	**Off-Site**	**Supervisor Review**	**Audit Scheduled**	**Findings**
	1. OMPP or MFCU marked **urgent.** 2. ISDH referrals. 3. Administar referrals. 4. Top 3 Algorithm rank (excluding false positives and at discretion of PI based on the nature of other referrals). 5. DSS Profiler Top Provider Ranking (will be defined further). 6. Referrals including falsifying/altering records or other examples of fraud/abuse identified in complaint. 7. High risk to close/flight risk. 8. High risk to shred/destroy documentation. 9. Multiple PI referrals for the same issue may increase priority level. 10. Complaints received from other providers or current/previous employees of the provider.	Complete within **30 days** from assignment to SUR Reviewer.	Discuss case priority with Supervisor and revise as needed.	Audit must be scheduled to occur within **60 days** after the approved/signed offsite is returned to Reviewer. This is based on resource availability and at the discretion of management.	Reviewer and Supervisor discuss case and revise pric as needed after the audit is completed. The findings m also be approved by MFCU

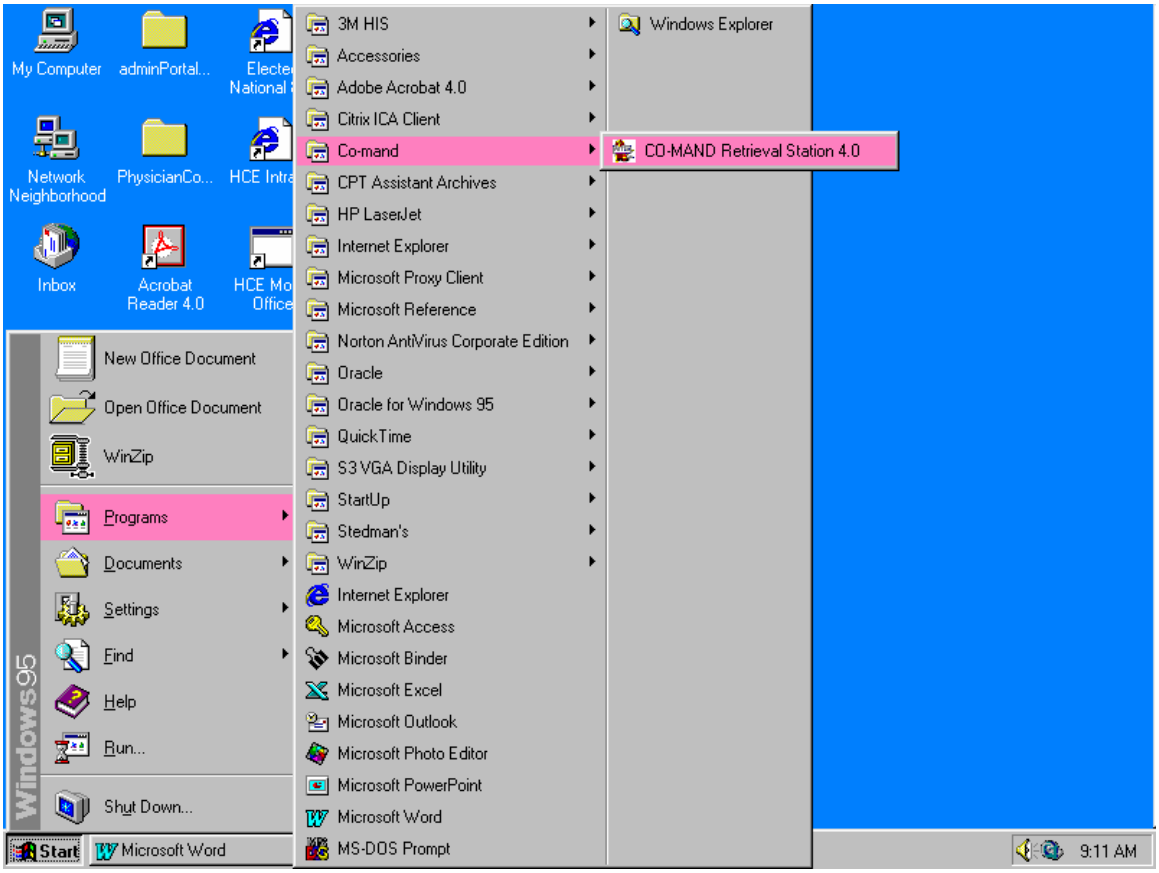
EXHIBIT IV – 5
CASE PRIORITY (Continued)

YELLOW PRIORITY (MID-LEVEL)					
Staff Member	PI Staff	SUR Reviewer	SUR Supervisor	SUR Reviewer	SUR Reviewer
Action	**PI Referral**	**Off-Site**	**Supervisor Review**	**Audit Scheduled**	**Findings**
	1. MP/PA referrals. 2. Lower algorithm ranking; however, no other PI referrals for the provider. 3. Continued/multiple referrals for the provider, but no ranking on algorithm or DSS profiler.	Complete within **60 days** from assignment to SUR Reviewer.	Discuss case priority with Supervisor and revise as needed.	Audit must be scheduled to occur within **90 days** after the approved/signed offsite is returned to Reviewer. This is based on resource availability and at the discretion of management.	Reviewer and Supervisor discuss case and revise priority as needed after the audit is completed. The findings must also be approved by MFCU.

EXHIBIT IV – 5
CASE PRIORITY (Continued)

RED PRIORITY (LOW-LEVEL)					
Staff Member	PI Staff	SUR Reviewer	SUR Supervisor	SUR Reviewer	SUR Reviewer
Action	**PI Referral**	**Off-Site**	**Supervisor Review**	**Audit Scheduled**	**Findings**
	1. Standard profile ranking. 2. Few PI referrals, no examples of fraud/abuse identified. 3. Non-compliance with program guidelines (i.e., not submitting documentation when requested.) 4. Follow-up reviews. 5. Providers that have never been audited (random selection), or previously audited with no findings (follow-up).	Complete within **90 days** from assignment to SUR Reviewer.	Discuss case priority with Supervisor and revise as needed.	Audit must be scheduled to occur within **60-90 days** after the approved/signed offsite is returned to Reviewer. This is based on resource availability and at the discretion of management.	Reviewer and Supervisor discuss case and revise priority as needed after the audit is completed. The findings must also be approved by MFCU.

FIGURE IV – 1
DESKTOP CO-MAND

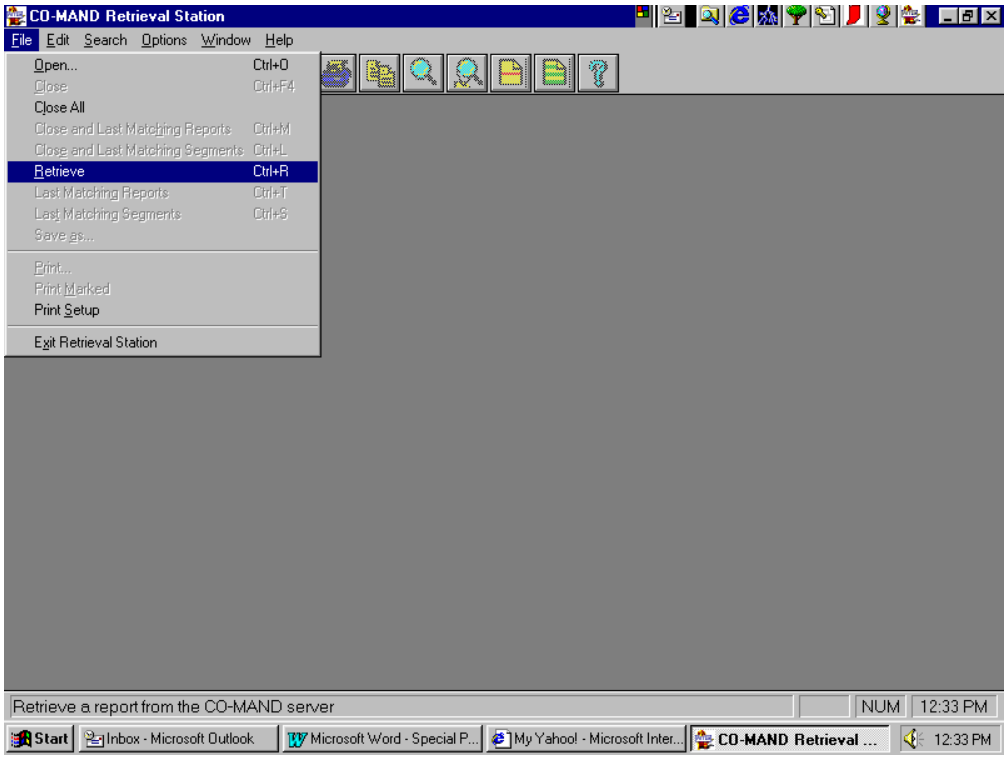


(2) Select the CO-MAND Icon from the Reviewer's desktop or go to Start Programs and Select CO-MAND. This process will bring the SUR Reviewer into the CO-MAND Retrieval Station 4.0.

(3) Enter the username as HCEXCEL and password as reports4u.

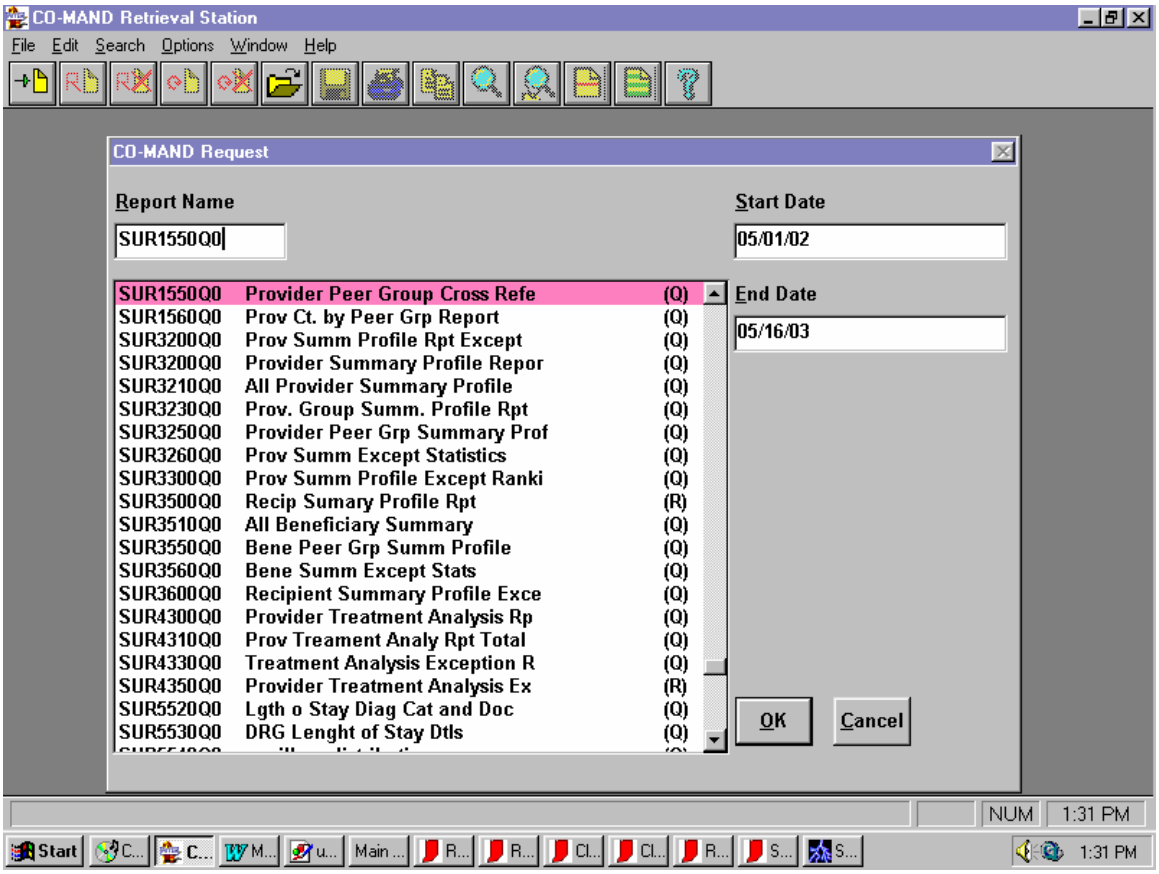
(4) The main window is the initial window viewed upon entry into the CO-MAND Retrieval Station. This window is used to gain access and retrieve the necessary reports to perform the off-site desk review.

FIGURE IV – 2
CO-MAND RETRIEVAL STATION FILE MENU



(5) To access the CO-MAND Request screen go to File-Retrieve.

FIGURE IV – 3
CO-MAND REQUEST



(6) The CO-MAND Request screen **Figure IV – 3** will display a list of all reports available to the SUR Reviewer.

(7) SURS 1550-Q (Provider to Peer Group Cross Reference): This report displays the peer group(s) in which each provider is active.

(9) SURS 1560-Q (Provider Count by Peer Group Report): This report displays all peer groups within each category of service along with a count of active providers in each peer group. This report allows the SUR Reviewer to analyze the appropriateness of the peer group structure and evaluate the effect of peer group changes before the changes are implemented.

(10) SURS 3300-Q (Provider Summary Exception Ranking Report): This report is utilized in selecting providers for review. Once a provider is selected from the ranking report, that provider's summary profile is reviewed to determine if further investigation is warranted.

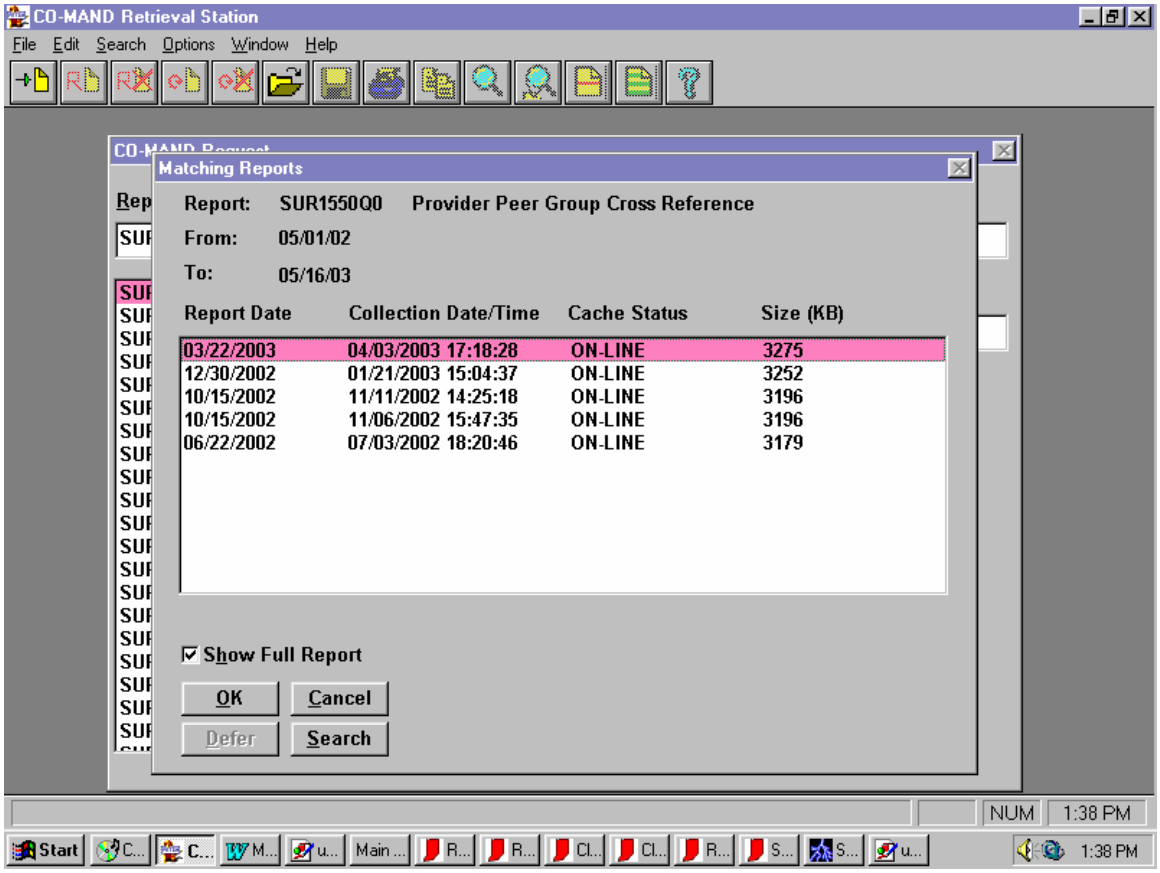
(11) SURS 3200-Q (Provider Summary Profile Exceptions): This report is used to perform the initial review of the provider's practice. The purpose of this report is to monitor significant characteristics of provider quality and quantity of medical care based on user-defined

parameters. It provides a statistical summary of provider activity during the time periods being reported.

(12) SURS 3210-Q (Provider Summary Profile Report-Total List): This is a large report divided into segments and subdivided into sequences. This report contains summary profiles for all providers in each category of service who meet activity minimums during the reference period. Enter the report name or scroll through the report to retrieve a report segment.

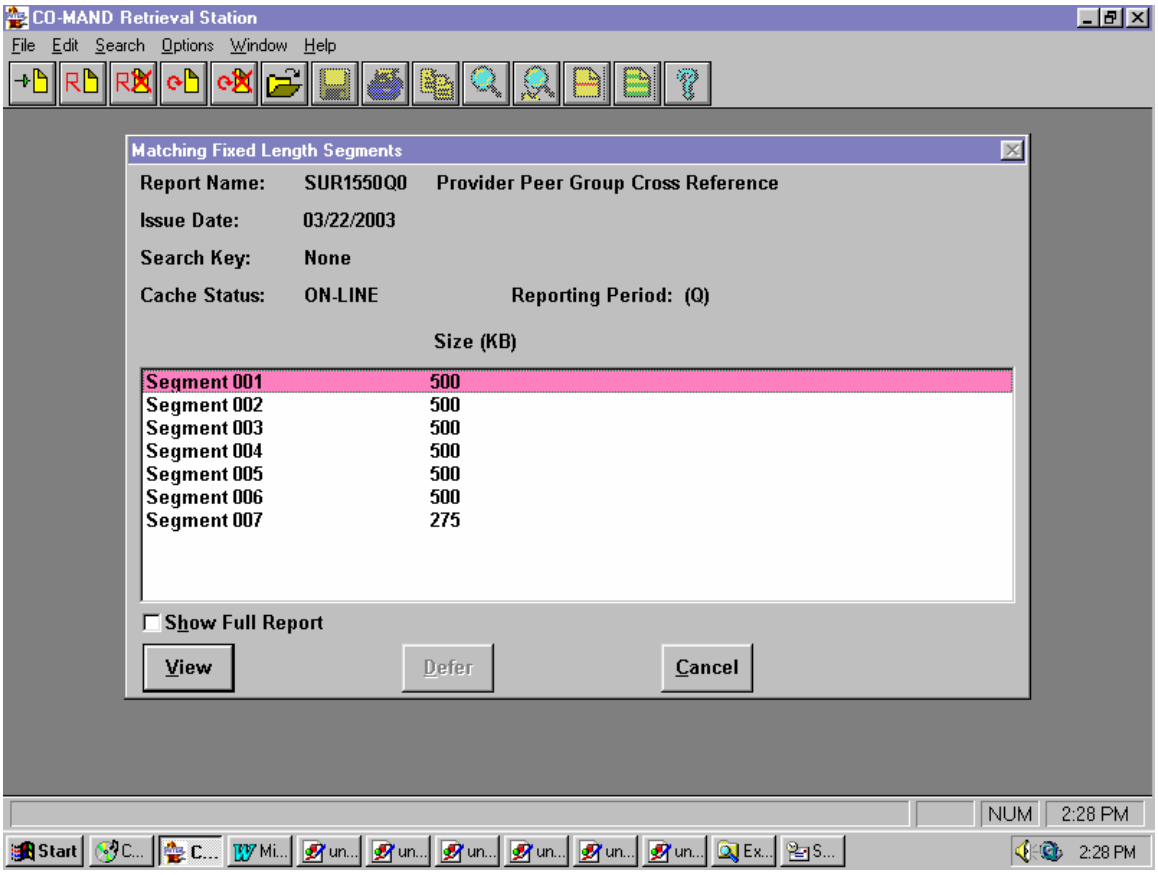
(13) Enter the start date by using the format MM/DD/YY in the Start Date Field.
Enter the end date by using the format MM/DD/YY in the End Date Field and Select OK.

FIGURE IV – 4
CO-MAND MATCHING REPORTS



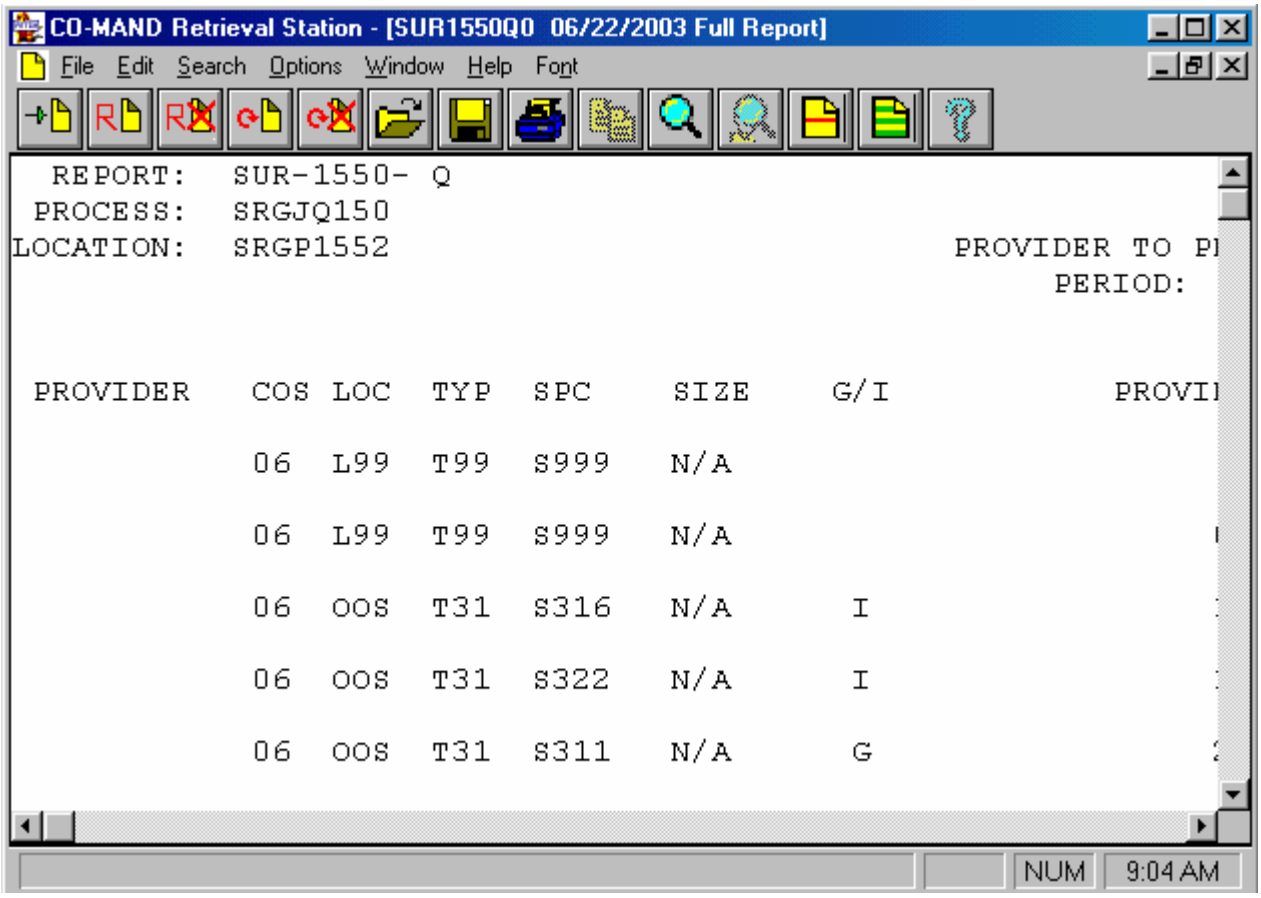
(14) The CO-MAND Matching Reports Screen will display the report name and criteria entered in the previous screen. Select the report to be viewed and choose OK.

FIGURE IV – 5
CO-MAND MATCHING FIXED LENGTH SEGMENTS



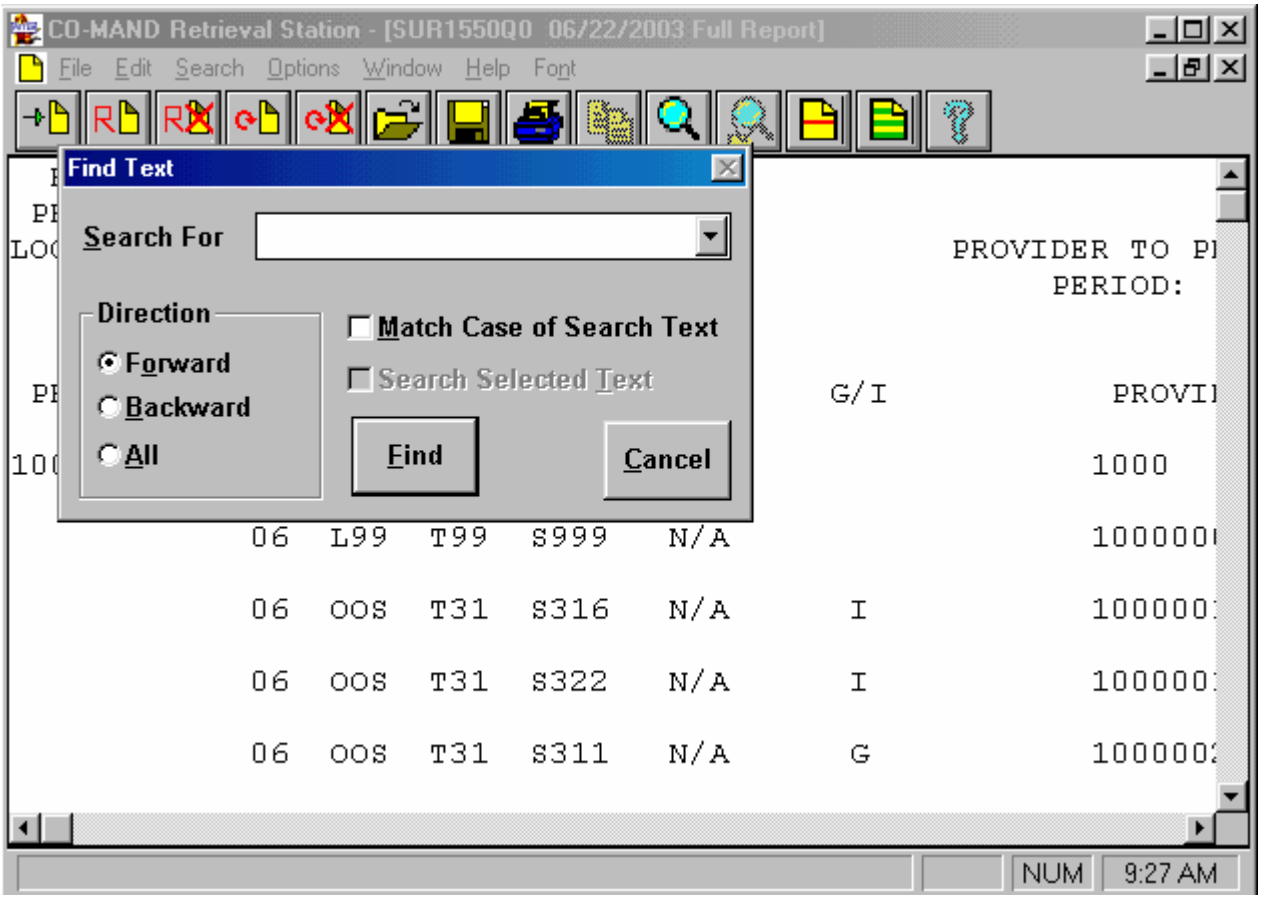
(15) CO-MAND Matching Fixed Length Segments will display the matching fixed length segments. These segments are displayed in the order they appear in the report. Choose a segment to view by highlighting it with the cursor and selecting View.

FIGURE IV – 6
CO-MAND RETRIEVAL STATION SUR 1550Q FULL REPORT



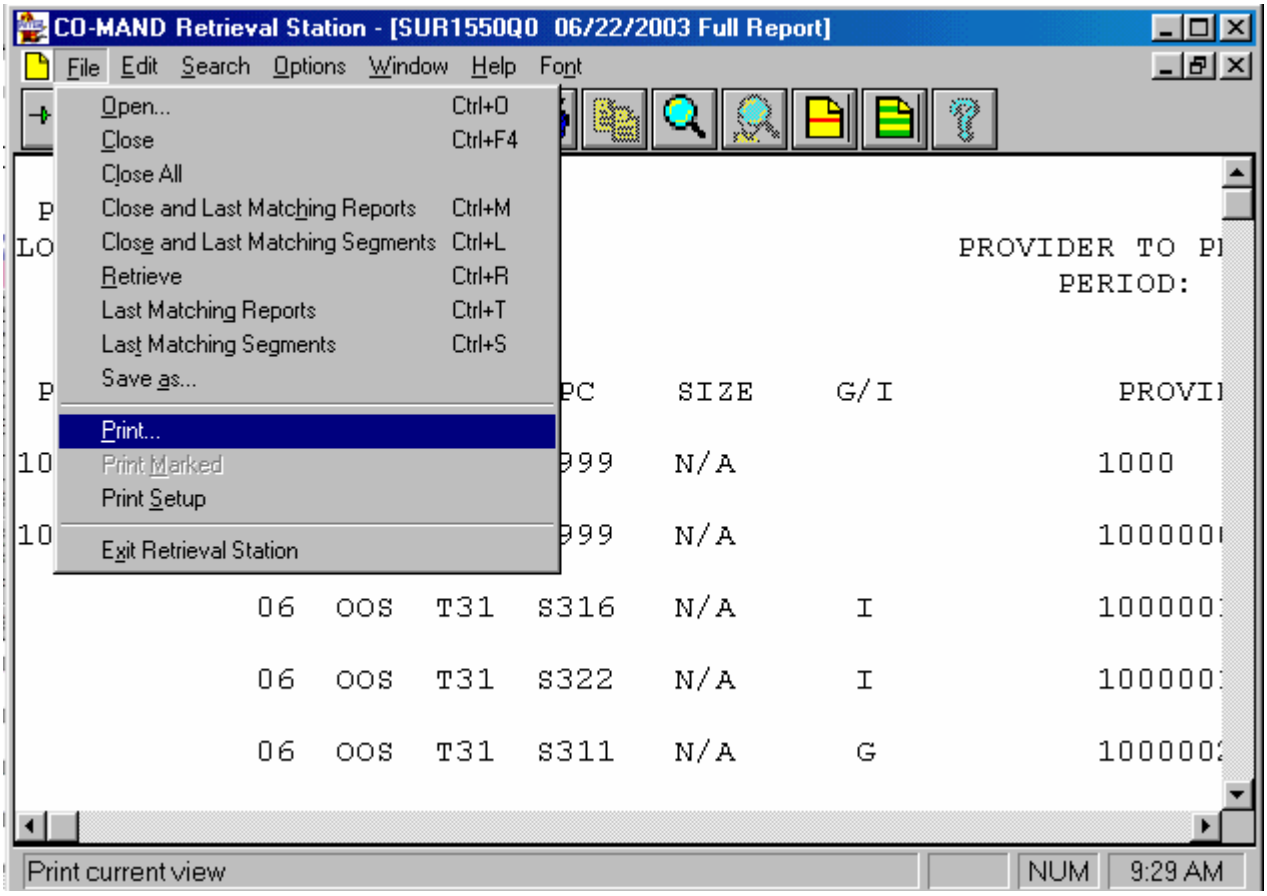
(16) The CO-MAND Report Segment displays the report name, report number, review period, provider numbers, category of service, provider type, provider specialty, size, and if the provider is an individual or a member of a group practice.

FIGURE IV – 7
CO-MAND RETRIEVAL STATION SUR 1550Q FULL REPORT



(17) Locate the provider for review by selecting the find function or the magnifying glass located on the CO-MAND toolbar.
(18) Enter the provider number in the Find Text screen.
(19) Select Find and the provider number will be highlighted while bringing the cursor to its location.

FIGURE IV – 8
CO-MAND RETRIEVAL STATION SUR 1550Q FULL REPORT



(20) Print the appropriate report by selecting File-Print. Examples of commonly used reports are displayed in **Figures IV – 9** through **Figure IV – 12**.

FIGURE IV – 9
CO-MAND RETRIEVAL STATION SUR 1560Q FULL REPORT

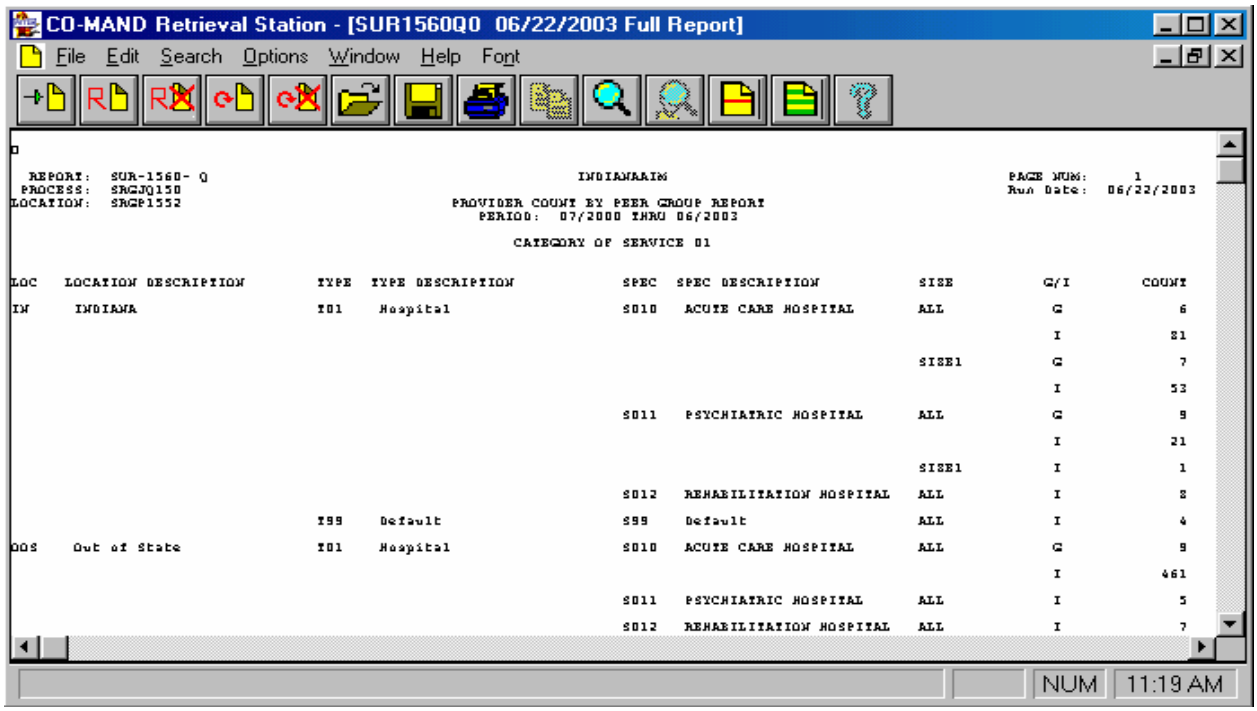
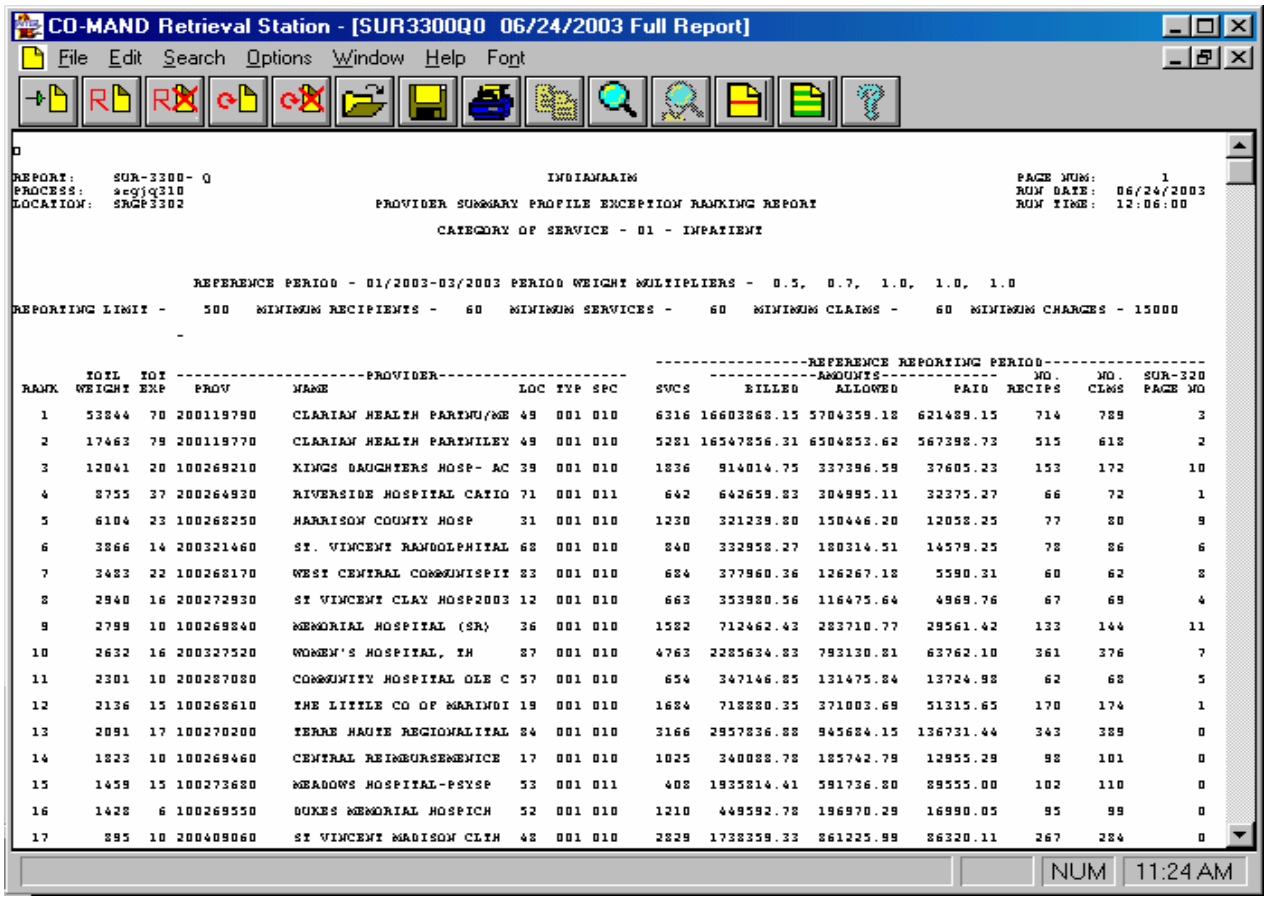


FIGURE IV – 10
CO-MAND SUR 3300Q FULL REPORT



CO-MAND Retrieval Station - [SUR3300Q0 06/24/2003 Full Report]

File Edit Search Options Window Help Font

REPORT: SUR-3300- Q
PROCESS: aegjq310
LOCATION: SRGP3302

INDIANAAIM

PROVIDER SUMMARY PROFILE EXCEPTION RANKING REPORT

PAGE NUM: 1
RUN DATE: 06/24/2003
RUN TIME: 12:06:00

CATEGORY OF SERVICE - 01 - INPATIENT

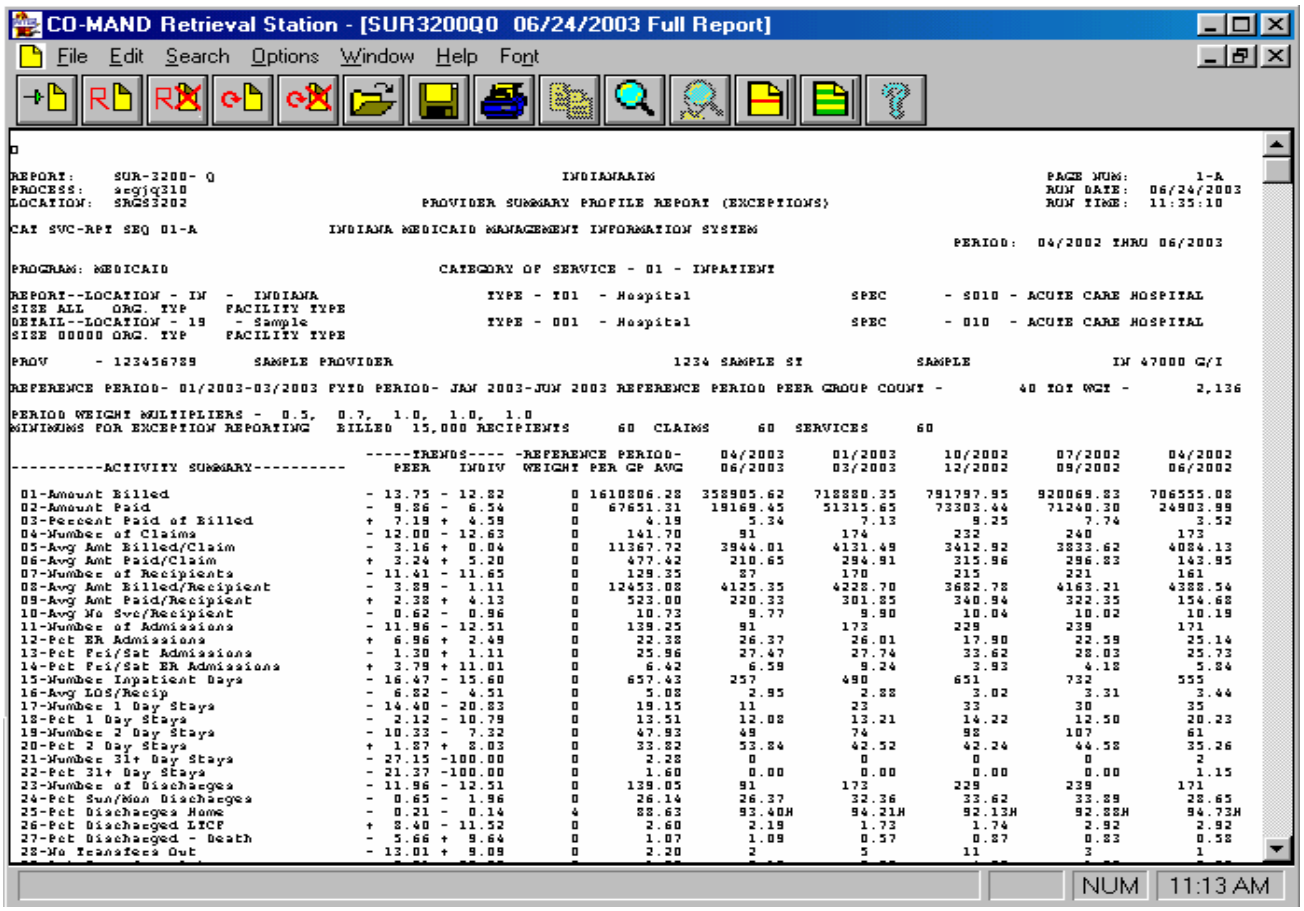
REFERENCE PERIOD - 01/2003-03/2003 PERIOD WEIGHT MULTIPLIERS - 0.5, 0.7, 1.0, 1.0, 1.0

REPORTING LIMIT - 500 MINIMUM RECIPIENTS - 60 MINIMUM SERVICES - 60 MINIMUM CLAIMS - 60 MINIMUM CHARGES - 15000

RANK	TOTL WEIGHT	TOT EXP	PROV	NAME	LOC	TYP	SPC	SVCS	BILLED	ALLOWED	PAID	NO. RECIPS	NO. CLMS	SUR-320 PAGE NO
1	53844	70	200119790	CLARIAN HEALTH PARTNU/ME	49	001	010	6316	16603868.15	5704359.18	621489.15	714	789	3
2	17463	79	200119770	CLARIAN HEALTH PARTNILEY	49	001	010	5281	16547856.31	6504853.62	567398.73	515	618	2
3	12041	20	100269210	KINGS DAUGHTERS HOSP- AC	39	001	010	1836	914014.75	337396.59	37605.23	153	172	10
4	8755	37	200264930	RIVERSIDE HOSPITAL CATIO	71	001	011	642	642659.83	304995.11	32375.27	66	72	1
5	6104	23	100268250	HARRISON COUNTY HOSP	31	001	010	1230	321239.80	150446.20	12058.25	77	80	9
6	3866	14	200321460	ST. VINCENT RANDOLPHITAL	68	001	010	840	332958.27	180314.51	14579.25	78	86	6
7	3483	22	100268170	WEST CENTRAL COMMUNISPIT	83	001	010	684	377960.36	126267.18	5590.31	60	62	8
8	2940	16	200272930	ST VINCENT CLAY HOSP2003	12	001	010	663	353980.56	116475.64	4969.76	67	69	4
9	2799	10	100269840	MEMORIAL HOSPITAL (SR)	36	001	010	1582	712462.43	283710.77	29561.42	133	144	11
10	2632	16	200327520	WOMEN'S HOSPITAL, IN	87	001	010	4763	2285634.83	793130.81	63762.10	361	376	7
11	2301	10	200287080	COMMUNITY HOSPITAL OLE C	57	001	010	654	347146.85	131475.84	13724.98	62	68	5
12	2136	15	100268610	THE LITTLE CO OF MARINDI	19	001	010	1684	718880.35	371003.69	51315.65	170	174	1
13	2091	17	100270200	TERRE HAUTE REGIONALITAL	84	001	010	3166	2957836.88	945684.15	136731.44	343	389	0
14	1823	10	100269460	CENTRAL REIMBURSEMENICE	17	001	010	1025	340088.78	185742.79	12955.29	98	101	0
15	1459	15	100273680	MEADOWS HOSPITAL-PSYSP	53	001	011	408	1935814.41	591736.80	89555.00	102	110	0
16	1428	6	100269550	DUKES MEMORIAL HOSPICH	52	001	010	1210	449592.78	196970.29	16990.05	95	99	0
17	895	10	200409060	ST VINCENT MADISON CLIN	48	001	010	2829	1738359.33	861225.99	86320.11	267	284	0

NUM 11:24 AM

FIGURE IV – 11
CO-MAND SUR 3200Q FULL REPORT



REPORT: SUR-3200- Q INDIANAAIM PAGE NUM: 1-A
PROCESS: aegjq310 RUN DATE: 06/24/2003
LOCATION: SNGS3202 PROVIDER SUMMARY PROFILE REPORT (EXCEPTIONS) RUN TIME: 11:35:10

CAI SVC-RPT SEQ 01-A INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
PERIOD: 04/2002 THRU 06/2003

PROGRAM: MEDICAID CATEGORY OF SERVICE - 01 - INPATIENT

REPORT--LOCATION - IN - INDIANA TYPE - 001 - Hospital SPEC - 0010 - ACUTE CARE HOSPITAL
SISE ALL ORG. TYP FACILITY TYPE
DETAIL--LOCATION - 19 - Sample TYPE - 001 - Hospital SPEC - 010 - ACUTE CARE HOSPITAL
SISE 00000 ORG. TYP FACILITY TYPE

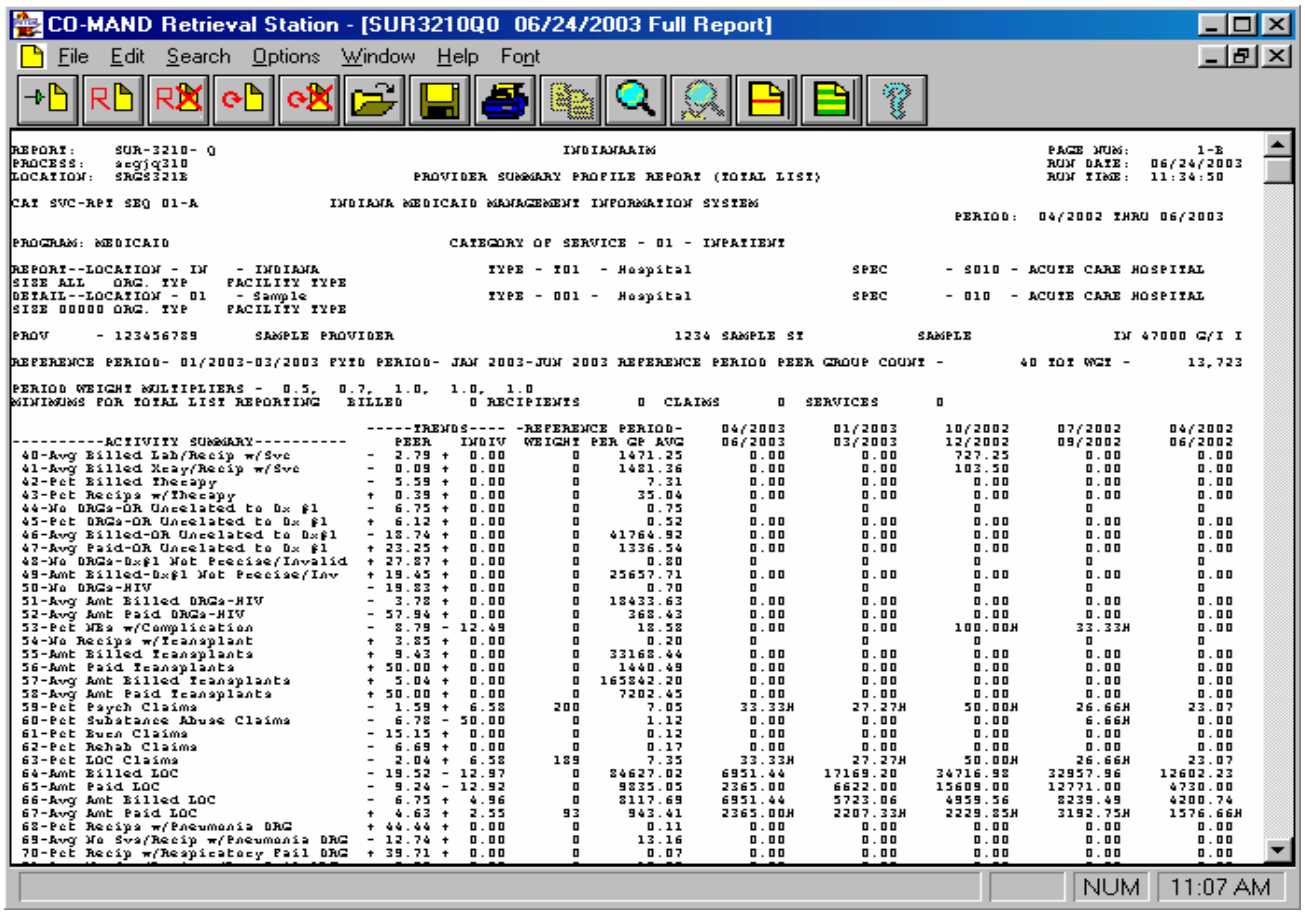
PROV - 123456789 SAMPLE PROVIDER 1234 SAMPLE ST SAMPLE IN 47000 G/I

REFERENCE PERIOD- 01/2003-03/2003 FYTD PERIOD- JAN 2003-JUN 2003 REFERENCE PERIOD PEER GROUP COUNT - 40 TOT WGT - 2,136

PERIOD WEIGHT MULTIPLIERS - 0.5, 0.7, 1.0, 1.0, 1.0
MINIMUMS FOR EXCEPTION REPORTING BILLED 15,000 RECIPIENTS 60 CLAIMS 60 SERVICES 60

----------ACTIVITY SUMMARY----------	-----TRENDS---- PEER	INDIV	-REFERENCE PERIOD- WEIGHT	PER GP AVG	04/2003 06/2003	01/2003 03/2003	10/2002 12/2002	07/2002 09/2002	04/2002 06/2002
01-Amount Billed	- 13.75	- 12.82	0	1610806.28	358905.62	718880.35	791797.95	920069.83	706555.08
02-Amount Paid	- 9.86	- 6.54	0	67651.31	19169.45	51315.65	73303.44	71240.30	24803.99
03-Percent Paid of Billed	+ 7.19	+ 4.59	0	4.19	5.34	7.13	9.25	7.74	3.52
04-Number of Claims	- 12.00	- 12.63	0	141.70	91	174	232	240	173
05-Avg Amt Billed/Claim	- 3.16	+ 0.04	0	11367.72	3944.01	4131.49	3412.92	3833.62	4084.13
06-Avg Amt Paid/Claim	+ 3.24	+ 5.20	0	477.42	210.65	294.91	315.96	296.83	143.95
07-Number of Recipients	- 11.41	- 11.65	0	128.35	87	170	215	221	161
08-Avg Amt Billed/Recipient	- 3.89	- 1.11	0	12453.08	4125.35	4228.70	3682.78	4163.21	4388.54
09-Avg Amt Paid/Recipient	+ 2.38	+ 4.13	0	523.00	220.33	301.85	340.94	322.35	154.68
10-Avg Wk Svc/Recipient	- 0.62	- 0.96	0	10.73	9.77	9.90	10.04	10.02	10.19
11-Number of Admissions	- 11.96	- 12.51	0	139.25	91	173	229	239	171
12-Pct ER Admissions	+ 6.96	+ 2.49	0	22.38	26.37	26.01	17.90	22.59	25.14
13-Pct Fri/Sat Admissions	- 1.30	+ 1.11	0	25.86	27.47	27.74	33.62	28.03	25.73
14-Pct Fri/Sat ER Admissions	+ 3.79	+ 11.01	0	6.42	6.59	9.24	3.93	4.18	5.84
15-Number Inpatient Days	- 16.47	- 15.60	0	657.42	257	490	651	732	555
16-Avg LOS/Recip	- 6.82	- 4.51	0	5.08	2.95	2.88	3.02	3.31	3.44
17-Number 1 Day Stays	- 14.40	- 20.83	0	19.15	11	23	33	30	35
18-Pct 1 Day Stays	- 2.12	- 10.79	0	13.51	12.08	13.21	14.22	12.50	20.23
19-Number 2 Day Stays	- 10.33	- 7.32	0	47.93	49	74	98	107	61
20-Pct 2 Day Stays	+ 1.87	+ 8.03	0	33.82	53.84	42.52	42.24	44.58	35.26
21-Number 31+ Day Stays	- 27.15	-100.00	0	2.28	0	0	0	0	2
22-Pct 31+ Day Stays	- 21.37	-100.00	0	1.60	0.00	0.00	0.00	0.00	1.15
23-Number of Discharges	- 11.96	- 12.51	0	139.05	91	173	229	239	171
24-Pct Sun/Mon Discharges	- 0.65	- 1.96	0	26.14	26.37	32.36	33.62	33.89	28.65
25-Pct Discharges Home	- 0.21	- 0.14	4	88.63	93.40H	94.21H	92.13H	92.88H	94.73H
26-Pct Discharged LTCF	+ 8.40	- 11.52	0	2.60	2.19	1.73	1.74	2.92	2.92
27-Pct Discharged - Death	- 5.66	+ 9.64	0	1.07	1.09	0.57	0.87	0.83	0.58
28-Wo Transfers Out	- 13.01	+ 9.09	0	2.20	2	5	11	3	1

FIGURE IV – 12
CO-MAND SUR 3210Q FULL REPORT



CO-MAND Retrieval Station - [SUR3210Q0 06/24/2003 Full Report]

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REPORT:     SUR-3210- Q                                  INDIANAAIM                                  PAGE NUM:        1-E
PROCESS:    srgjq310                                                                                 RUN DATE:   06/24/2003
LOCATION:   SRGS321E                  PROVIDER SUMMARY PROFILE REPORT (TOTAL LIST)                   RUN TIME:   11:34:50

CAT SVC-RPT SEQ 01-A              INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
                                                                                        PERIOD:  04/2002 THRU 06/2003

PROGRAM: MEDICAID                              CATEGORY OF SERVICE - 01 - INPATIENT

REPORT--LOCATION - IN    - INDIANA                  TYPE - 001  - Hospital              SPEC      - 8010 - ACUTE CARE HOSPITAL
SISE ALL    ORG. TYP     FACILITY TYPE
DETAIL--LOCATION - 01    - Sample                   TYPE - 001 -  Hospital              SPEC      - 010  - ACUTE CARE HOSPITAL
SISE 00000 ORG. TYP     FACILITY TYPE

PROV      - 123456789       SAMPLE PROVIDER                              1234 SAMPLE ST            SAMPLE                IN 47000 G/I I

REFERENCE PERIOD- 01/2003-03/2003 FYTD PERIOD- JAN 2003-JUN 2003 REFERENCE PERIOD PEER GROUP COUNT -        40 TOT WGT -      13,723

PERIOD WEIGHT MULTIPLIERS -  0.5,  0.7,  1.0,  1.0,  1.0
MINIMUMS FOR TOTAL LIST REPORTING   BILLED       0 RECIPIENTS      0  CLAIMS      0  SERVICES      0

                                  -----TRENDS----- -REFERENCE PERIOD-    04/2003     01/2003     10/2002     07/2002     04/2002
----------ACTIVITY SUMMARY----------    PEER    INDIV  WEIGHT PER GP AVG   06/2003     03/2003     12/2002     09/2002     06/2002
 40-Avg Billed Lab/Recip w/Svc        -  2.79 +  0.00        0    1471.25        0.00        0.00      727.25        0.00        0.00
 41-Avg Billed Xray/Recip w/Svc       -  0.09 +  0.00        0    1481.36        0.00        0.00      103.50        0.00        0.00
 42-Pct Billed Therapy                -  5.59 +  0.00        0       7.31        0.00        0.00        0.00        0.00        0.00
 43-Pct Recips w/Therapy              +  0.39 +  0.00        0      35.04        0.00        0.00        0.00        0.00        0.00
 44-No DRGs-OR Unrelated to Dx #1     -  6.75 +  0.00        0       0.75           0           0           0           0           0
 45-Pct DRGs-OR Unrelated to Dx #1    +  6.12 +  0.00        0       0.52        0.00        0.00        0.00        0.00        0.00
 46-Avg Billed-OR Unrelated to Dx#1   - 18.74 +  0.00        0   41764.92        0.00        0.00        0.00        0.00        0.00
 47-Avg Paid-OR Unrelated to Dx #1    + 23.25 +  0.00        0    1336.54        0.00        0.00        0.00        0.00        0.00
 48-No DRGs-Dx#1 Not Precise/Invalid  + 27.87 +  0.00        0       0.80           0           0           0           0           0
 49-Amt Billed-Dx#1 Not Precise/Inv   + 19.45 +  0.00        0   25657.71        0.00        0.00        0.00        0.00        0.00
 50-No DRGs-HIV                       - 19.83 +  0.00        0       0.70           0           0           0           0           0
 51-Avg Amt Billed DRGs-HIV           -  3.78 +  0.00        0   18433.63        0.00        0.00        0.00        0.00        0.00
 52-Avg Amt Paid DRGs-HIV             - 57.94 +  0.00        0     368.43        0.00        0.00        0.00        0.00        0.00
 53-Pct MDs w/Complication            -  8.79 - 12.49        0      18.58        0.00        0.00      100.00H      33.33H        0.00
 54-No Recips w/Transplant            +  3.85 +  0.00        0       0.20           0           0           0           0           0
 55-Amt Billed Transplants            +  9.43 +  0.00        0   33168.44        0.00        0.00        0.00        0.00        0.00
 56-Amt Paid Transplants              + 50.00 +  0.00        0    1440.49        0.00        0.00        0.00        0.00        0.00
 57-Avg Amt Billed Transplants        +  5.04 +  0.00        0  165842.20        0.00        0.00        0.00        0.00        0.00
 58-Avg Amt Paid Transplants          + 50.00 +  0.00        0    7202.45        0.00        0.00        0.00        0.00        0.00
 59-Pct Psych Claims                  -  1.59 +  6.58      200       7.05       33.33H      27.27H      50.00H      26.66H      23.07
 60-Pct Substance Abuse Claims        -  6.78 - 50.00        0       1.12        0.00        0.00        0.00        6.66H        0.00
 61-Pct Burn Claims                   - 15.15 +  0.00        0       0.12        0.00        0.00        0.00        0.00        0.00
 62-Pct Rehab Claims                  -  6.69 +  0.00        0       0.17        0.00        0.00        0.00        0.00        0.00
 63-Pct LOC Claims                    -  2.04 +  6.58      189       7.35       33.33H      27.27H      50.00H      26.66H      23.07
 64-Amt Billed LOC                    - 19.52 - 12.97        0   84627.02     6951.44    17169.20    34716.98    32957.96    12602.23
 65-Amt Paid LOC                      -  9.24 - 12.92        0    9835.05     2365.00     6622.00    15609.00    12771.00     4730.00
 66-Avg Amt Billed LOC                -  6.75 +  4.96        0    8117.69     6951.44     5723.06     4959.56     8239.49     4200.74
 67-Avg Amt Paid LOC                  +  4.63 +  2.55       93     943.41     2365.00H    2207.33H    2229.85H    3192.75H    1576.66H
 68-Pct Recips w/Pneumonia DRG        + 44.44 +  0.00        0       0.11        0.00        0.00        0.00        0.00        0.00
 69-Avg No Svs/Recip w/Pneumonia DRG  - 12.74 +  0.00        0      13.16        0.00        0.00        0.00        0.00        0.00
 70-Pct Recip w/Respiratory Fail DRG  + 39.71 +  0.00        0       0.07        0.00        0.00        0.00        0.00        0.00
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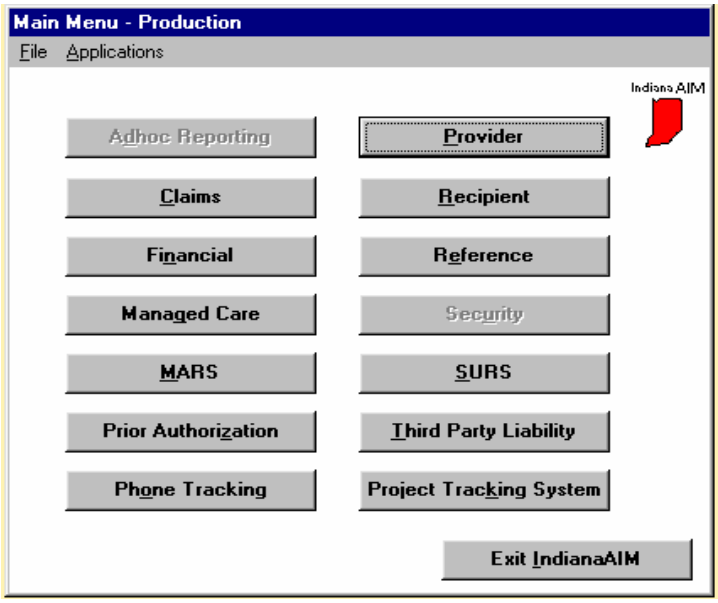
NUM 11:07 AM

e. The following procedure is utilized to obtain relevant information from Indiana*AIM* to support the off-site review process.

FIGURE IV – 13
INDIANA AIM LOGON

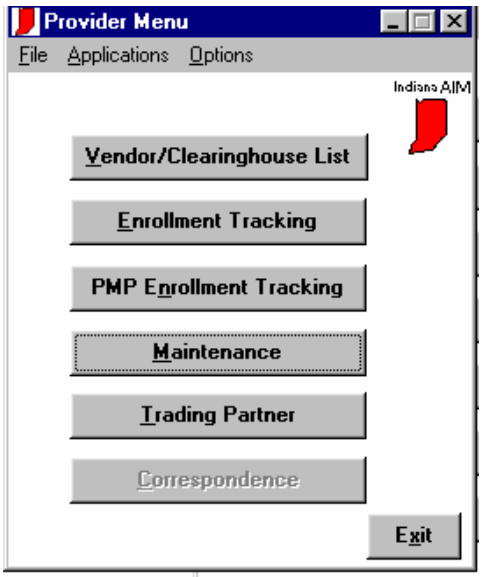
(1) Logon to Indiana*AIM*.

FIGURE IV – 14
MAIN MENU



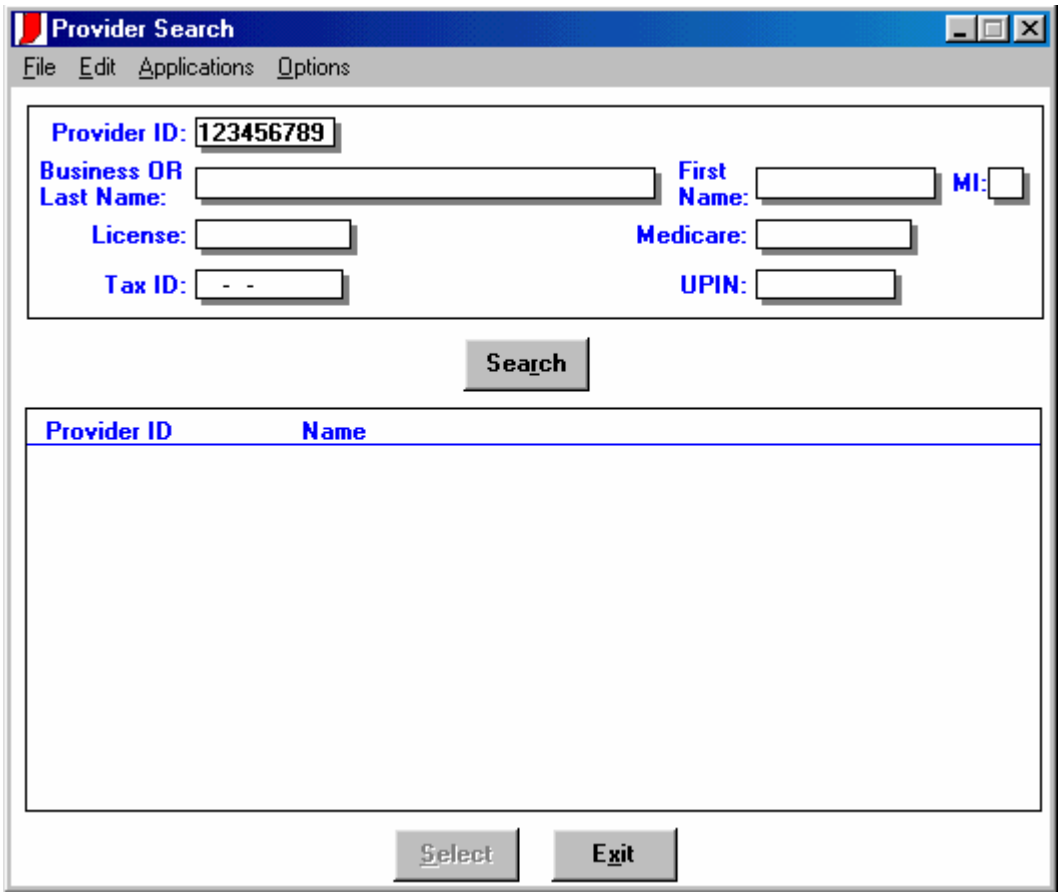
(2) Select Provider.

FIGURE IV – 15
PROVIDER MENU



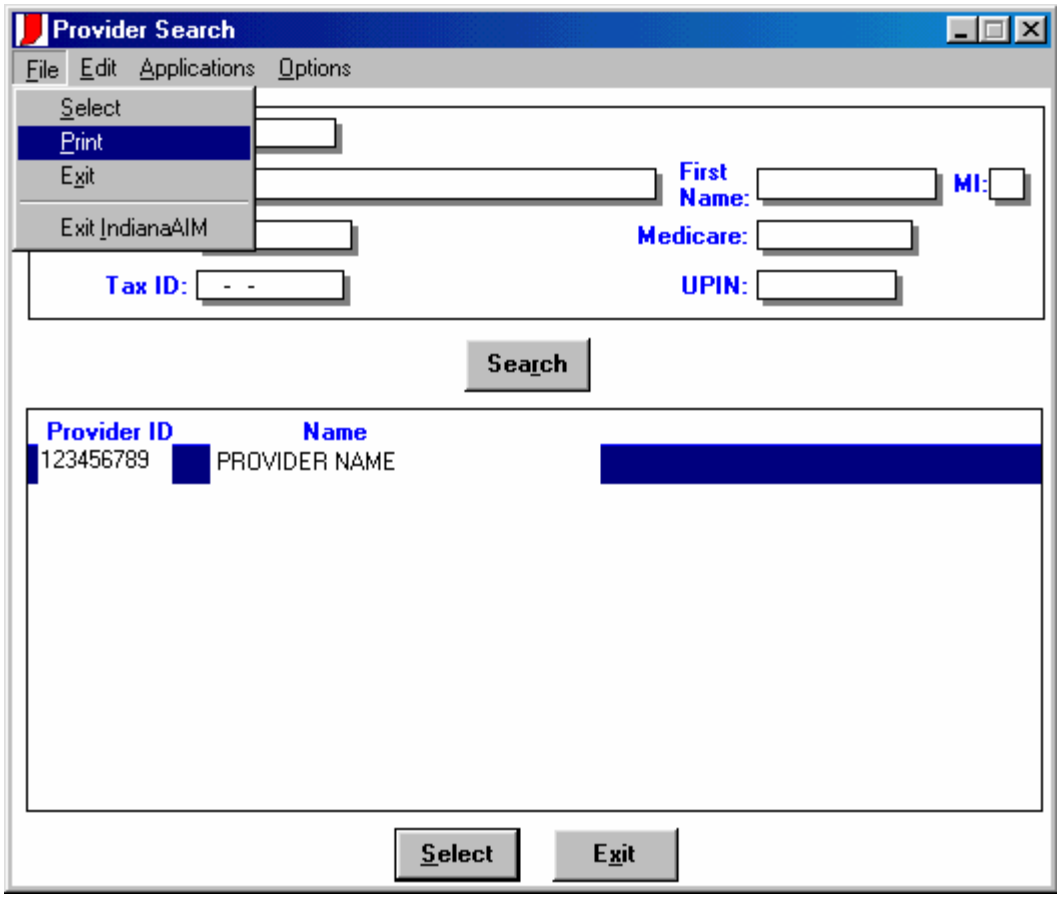
(3) Select Maintenance to access the Provider Search screen.

FIGURE IV – 16
PROVIDER SEARCH



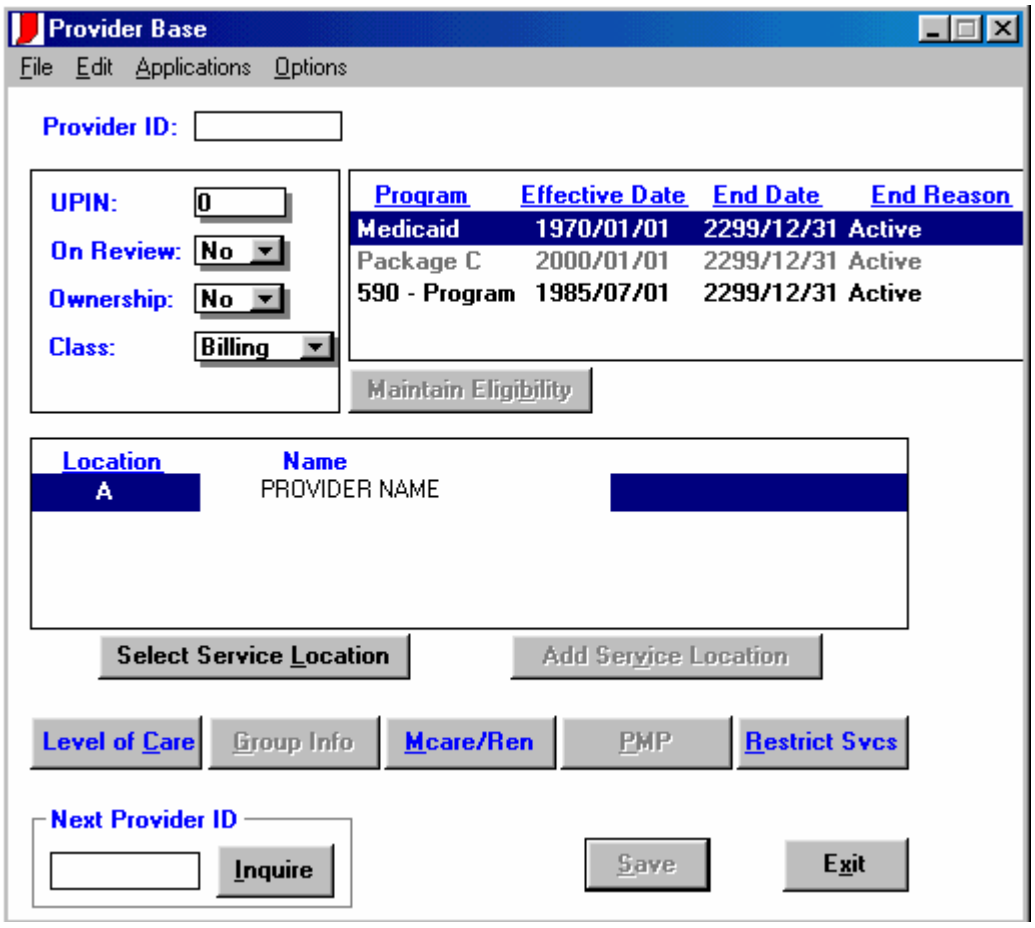
(4) Enter the provider name or number and select Search.

FIGURE IV – 17
PROVIDER SEARCH



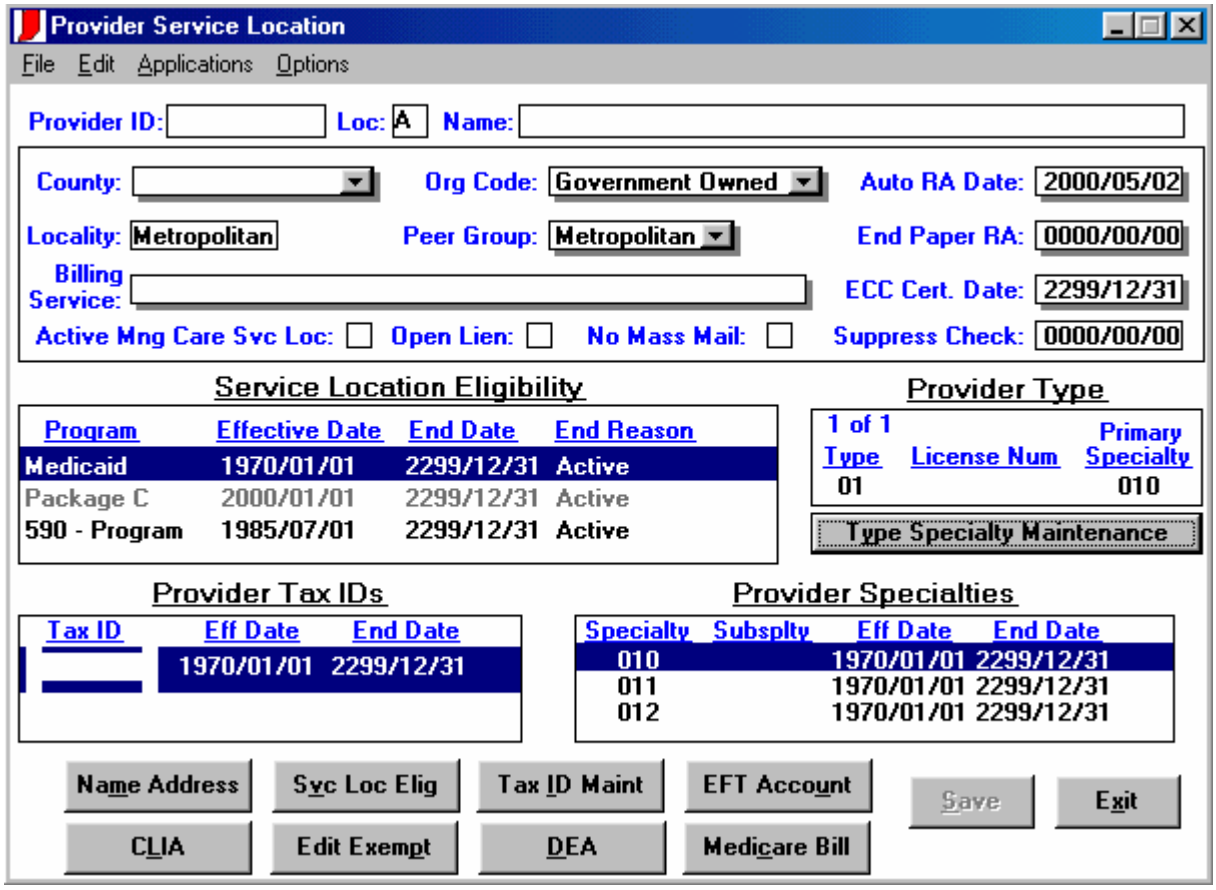
(5) Print the Provider Search screen by selecting File-Print. Place this information in the provider file. Choose Select.

FIGURE IV – 18
PROVIDER BASE



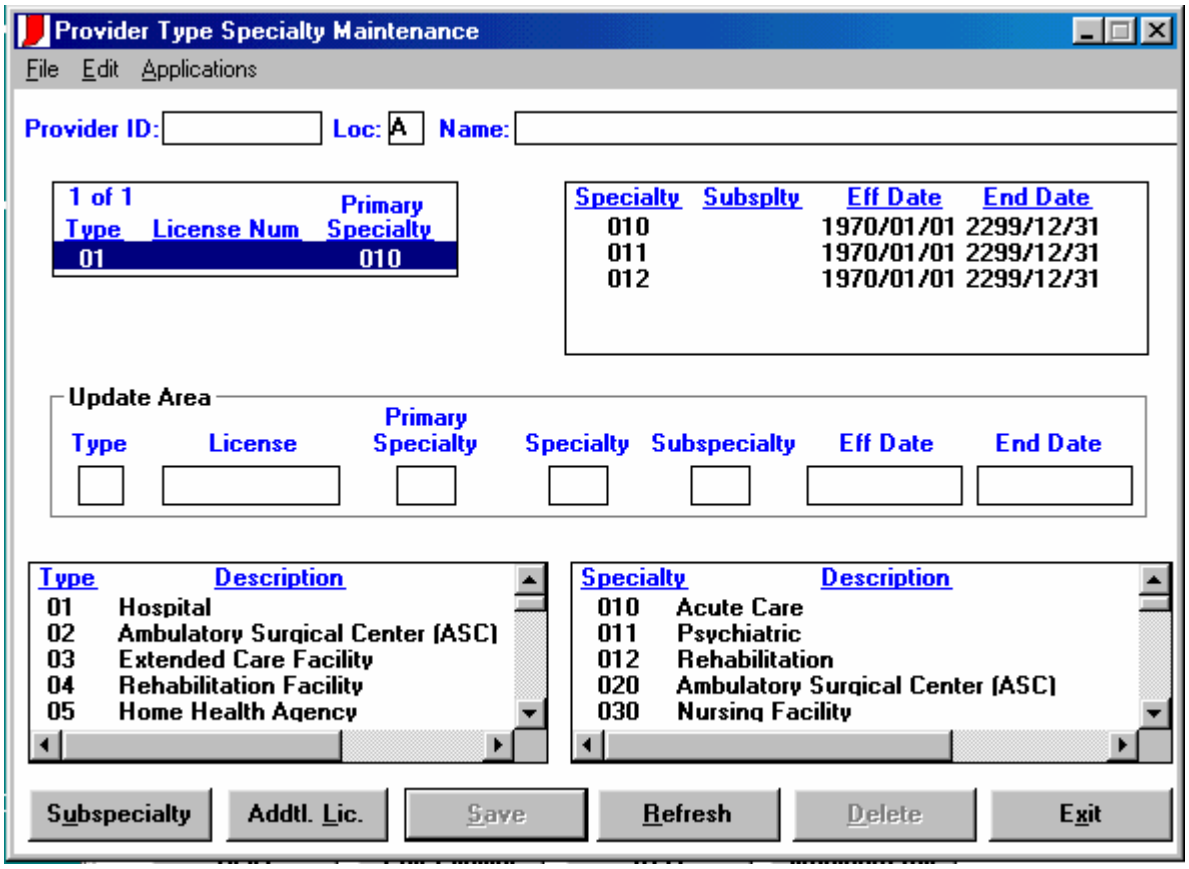
(6) Print the screen Provider Base and place the information in the provider file. Choose Select Service Location.

FIGURE IV – 19
PROVIDER SERVICE LOCATION



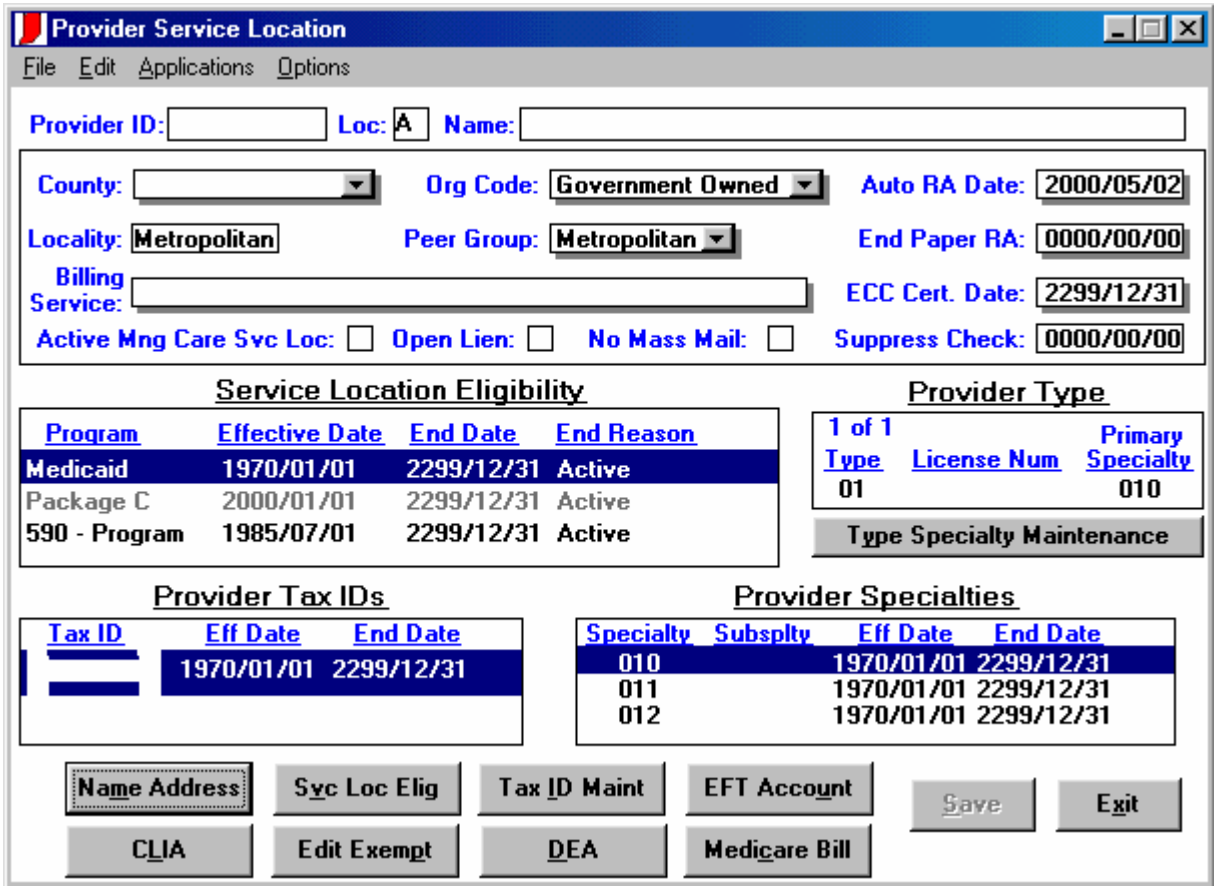
(7) Print the Provider Service Location screen and place the information in the provider file. Choose Type Specialty Maintenance.

FIGURE IV – 20
INDIANA AIM PROVIDER TYPE SPECIALTY MAINTENANCE



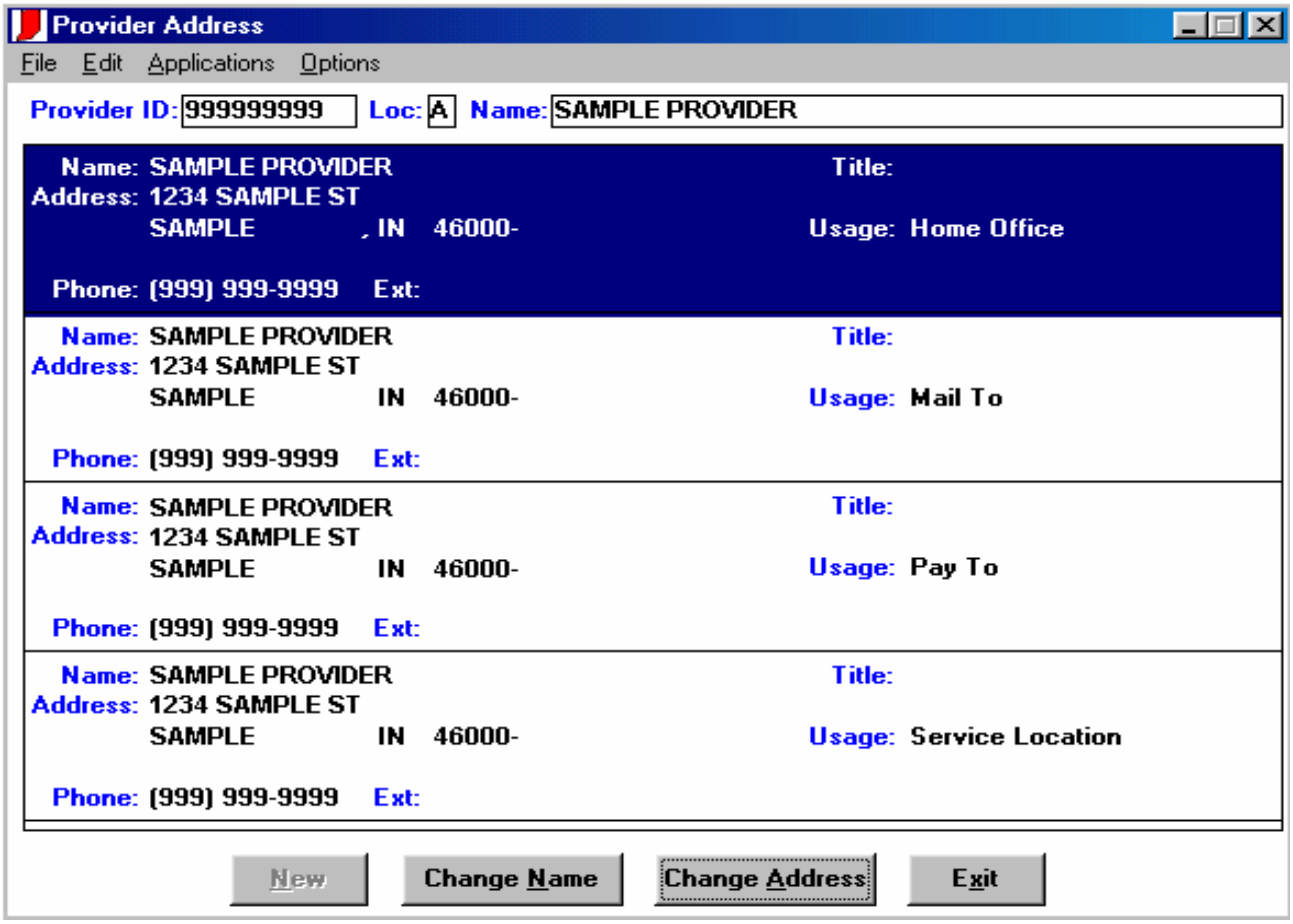
(8) Print the Provider Type Specialty Maintenance screen and place the information in the provider file. Select Exit to return to the Provider Service Location screen.

FIGURE IV – 21
PROVIDER SERVICE LOCATION



(9) Choose Name Address.

FIGURE IV – 22
INDIANA AIM PROVIDER ADDRESS

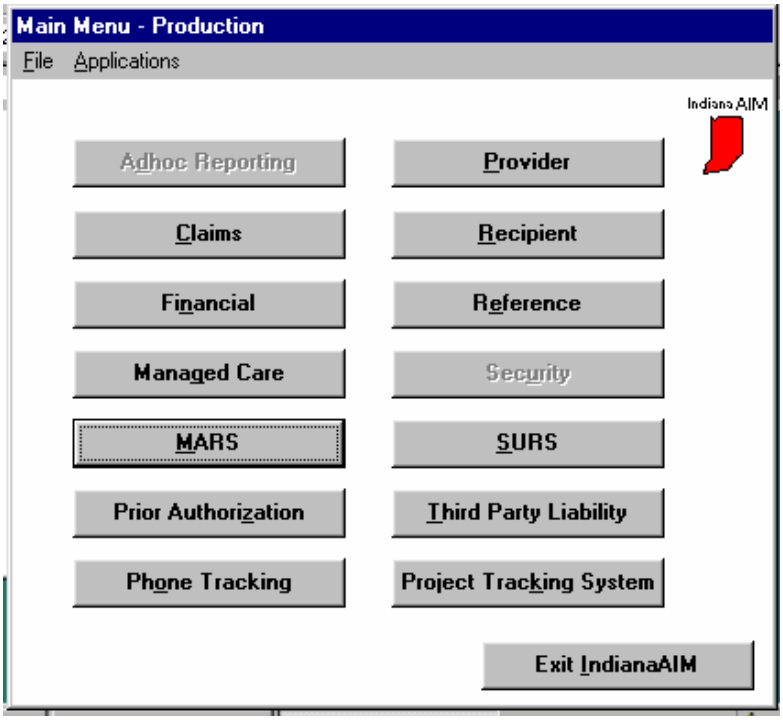


(10) Print the Provider Address screen and place the information in the provider file.
(11) Choose Exit.

f. MARS (Management and Administrative Reporting Screen)

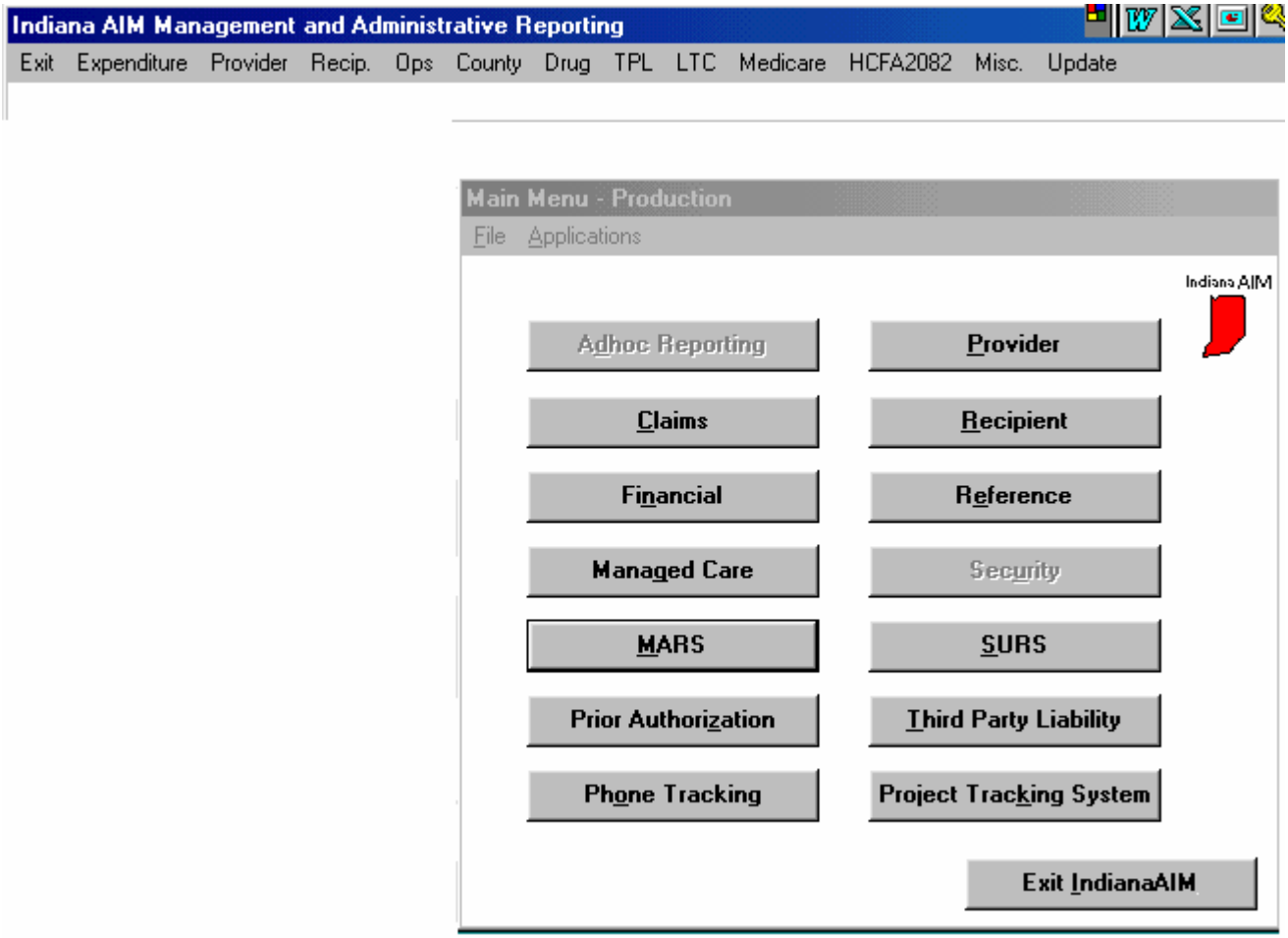
MARS is a reporting function that can be accessed from Indiana*AIM*. From the MARS database, total paid Medicaid dollars for specific time periods can be obtained. Printouts of the present year to date dollars paid, and dollars paid for the previous two calendar years should be included in the off-site desk review.

FIGURE IV – 23
MAIN MENU



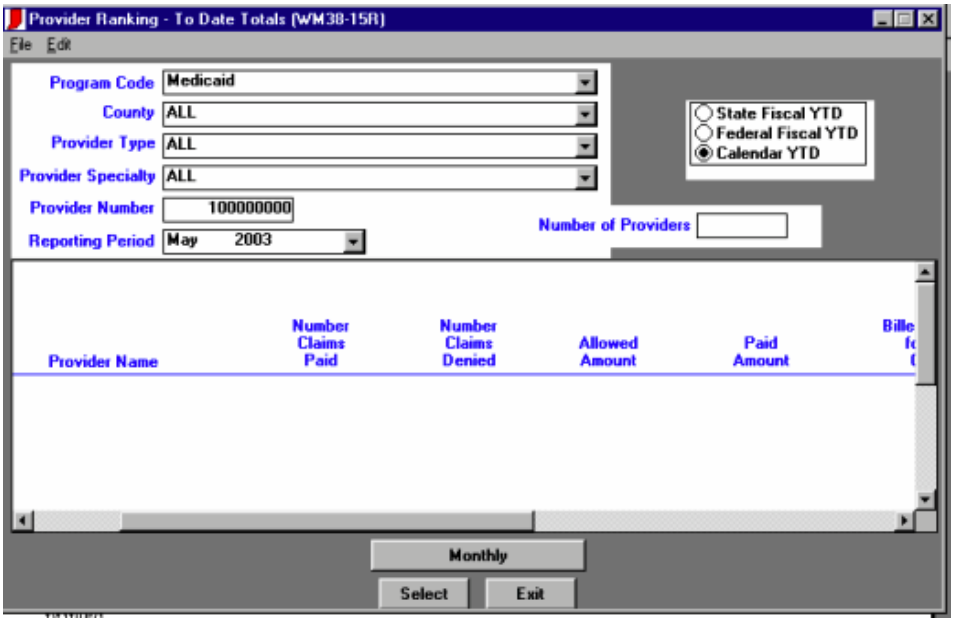
(1) Return to the Main Menu-Production and select MARS.

FIGURE IV – 24
INDIANA AIM MANAGEMENT AND ADMINISTRATIVE REPORTING



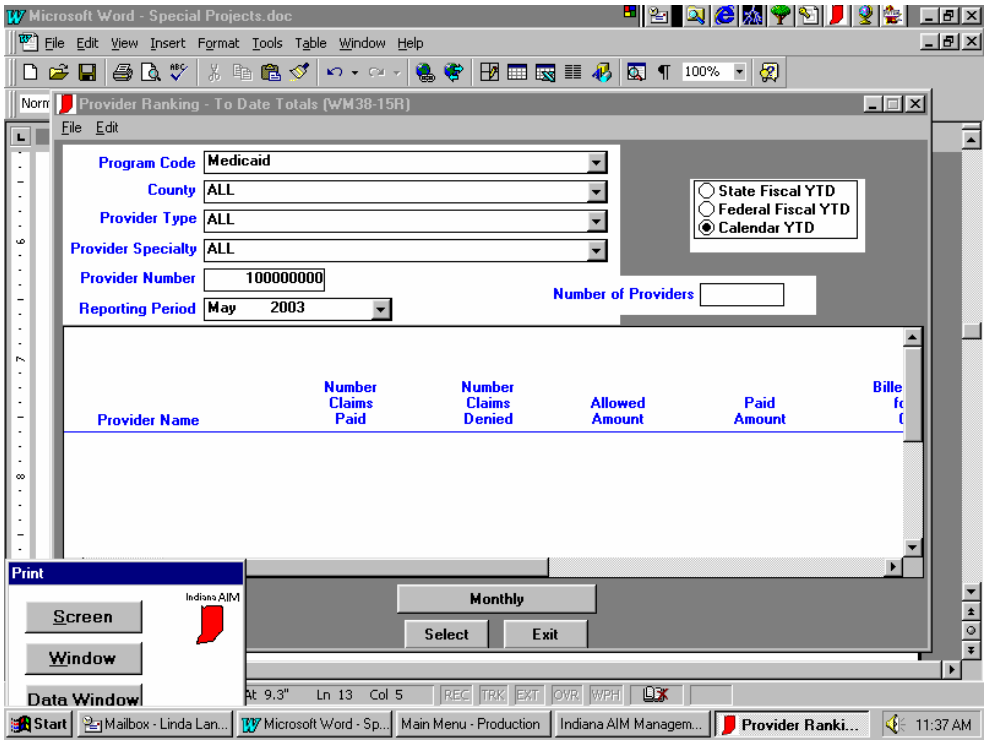
(2) From the toolbar select Provider-Ranking-Year to Date.

FIGURE IV – 25
PROVIDER RANKING – TO DATE TOTALS



(3) Select Calendar YTD in the upper right hand corner of the window.
(4) In the Program Code drop-down menu, select Medicaid.
(5) Enter the Provider Number in the appropriate field.
(6) In the Reporting Period drop-down menu, select the current month and year.
(7) Choose Select.
(8) Position the page with the left-to-right scroll bar so that the provider name and amount paid fields are visible, print the screen and place in the information into the provider file.

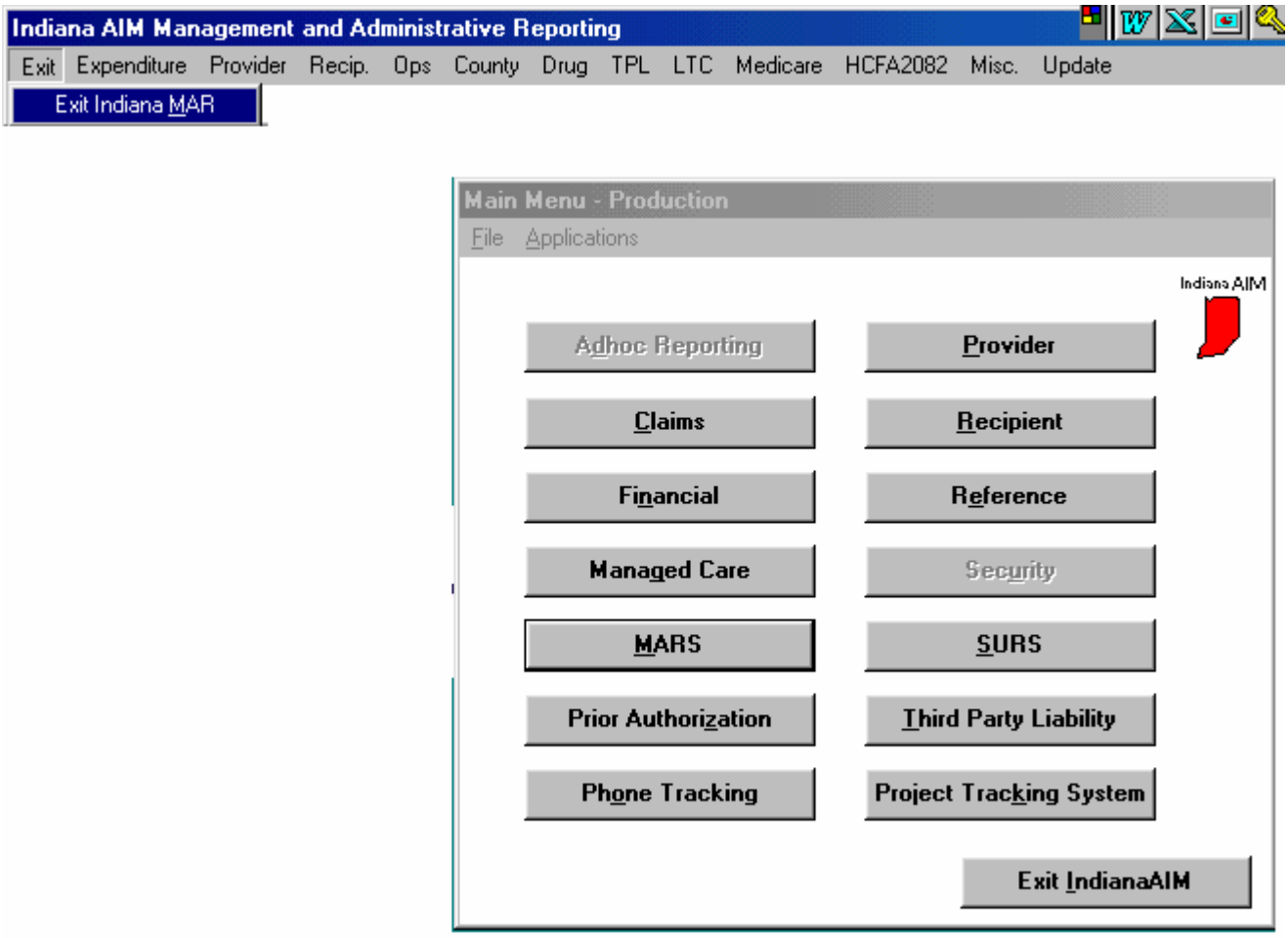
FIGURE IV – 26
PROVIDER RANKING PRINT



(9) Repeat steps 6-8 three more times selecting December, and year in the Reporting Period for each of the previous three years from the Reporting Period drop-down menu.

(10) Select Exit on the Provider Ranking window.

FIGURE IV – 27
MANAGEMENT AND ADMINISTRATIVE REPORTING



(11) Choose Exit-Exit Indiana MAR.

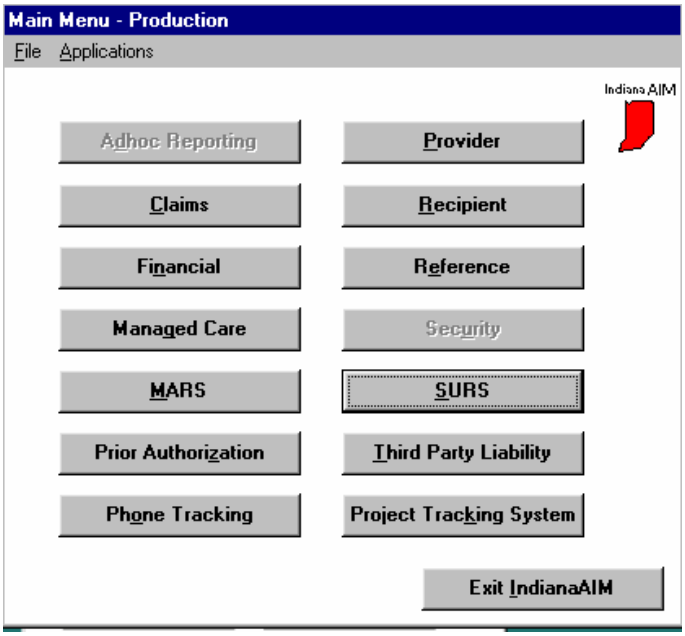
g. Provider Utilization Reports (SUR 1320)

The 1320 provider utilization report is a summary of billing practices for a specific time period. It is ordered from the SURS section of Indiana*AIM*. The report gives the total number of Medicaid claims paid and services provided in the identified time frame. The report also gives a breakdown of claims by HCPCS or procedure code and diagnosis. This report can be utilized to determine the appropriate size sample of claims for review to evaluate provider compliance with IHCP guidelines.

h. Process for Ordering a SUR 1320 Report

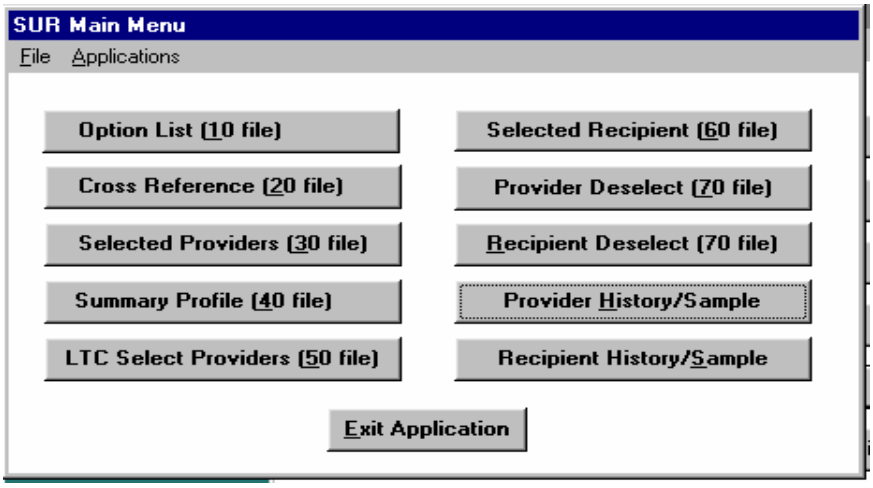
(1) Logon to Indiana*AIM*.

FIGURE IV – 28
MAIN MENU



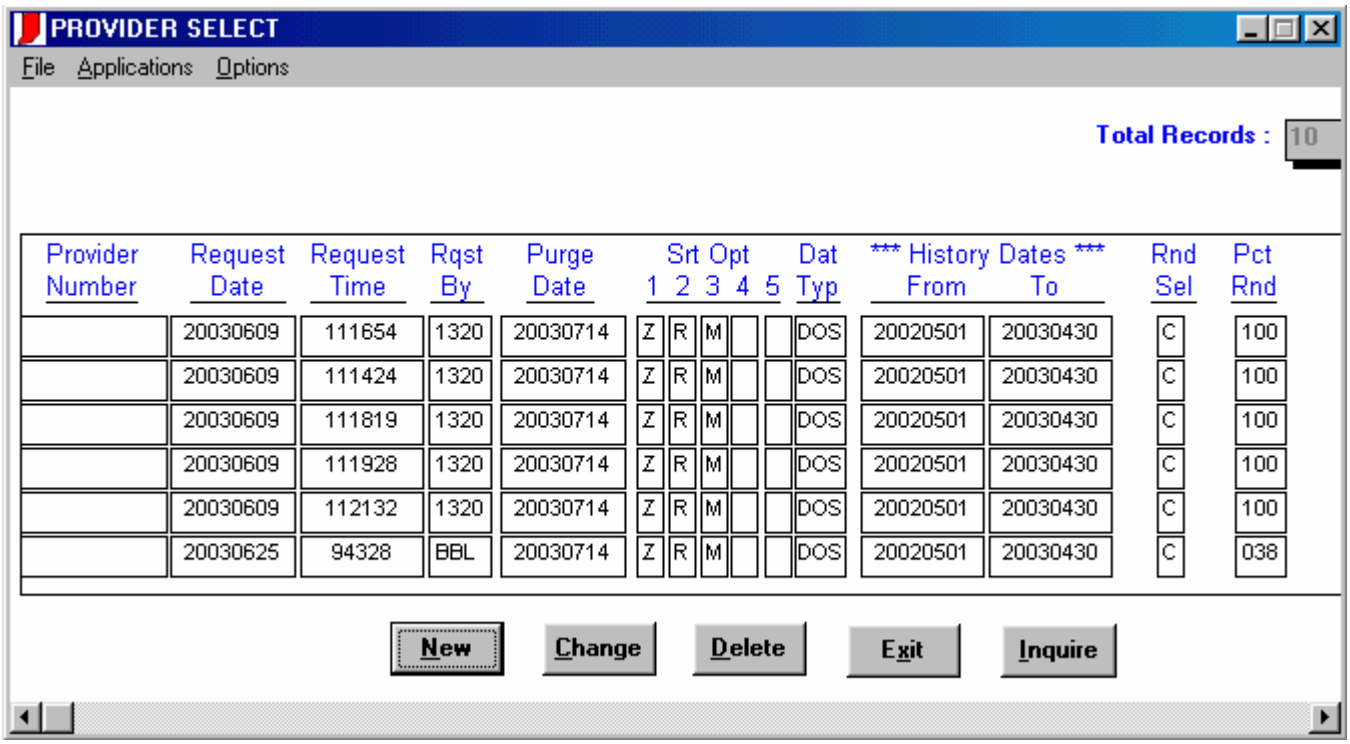
(2) Proceed to the Main Menu-Production of Indiana*AIM* and select SURS.

FIGURE IV – 29
SUR MAIN MENU



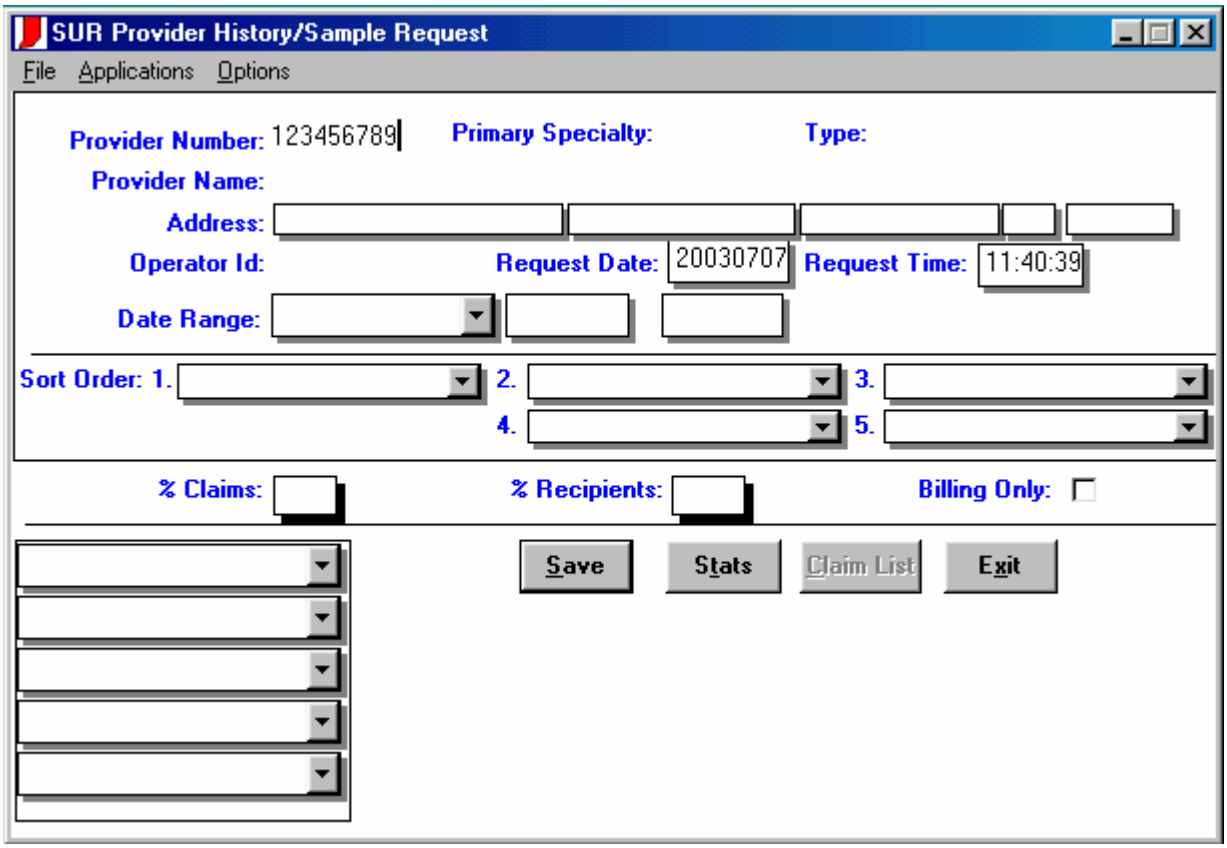
(3) Select Provider History/Sample in the SUR Main Menu.

FIGURE IV – 30
INDIANA AIM PROVIDER SELECT SCREEN



(4) Select New to begin process of requesting a 1320 provider utilization report.

FIGURE IV – 31
INDIANA AIM SUR PROVIDER HISTORY/SAMPLE REQUEST



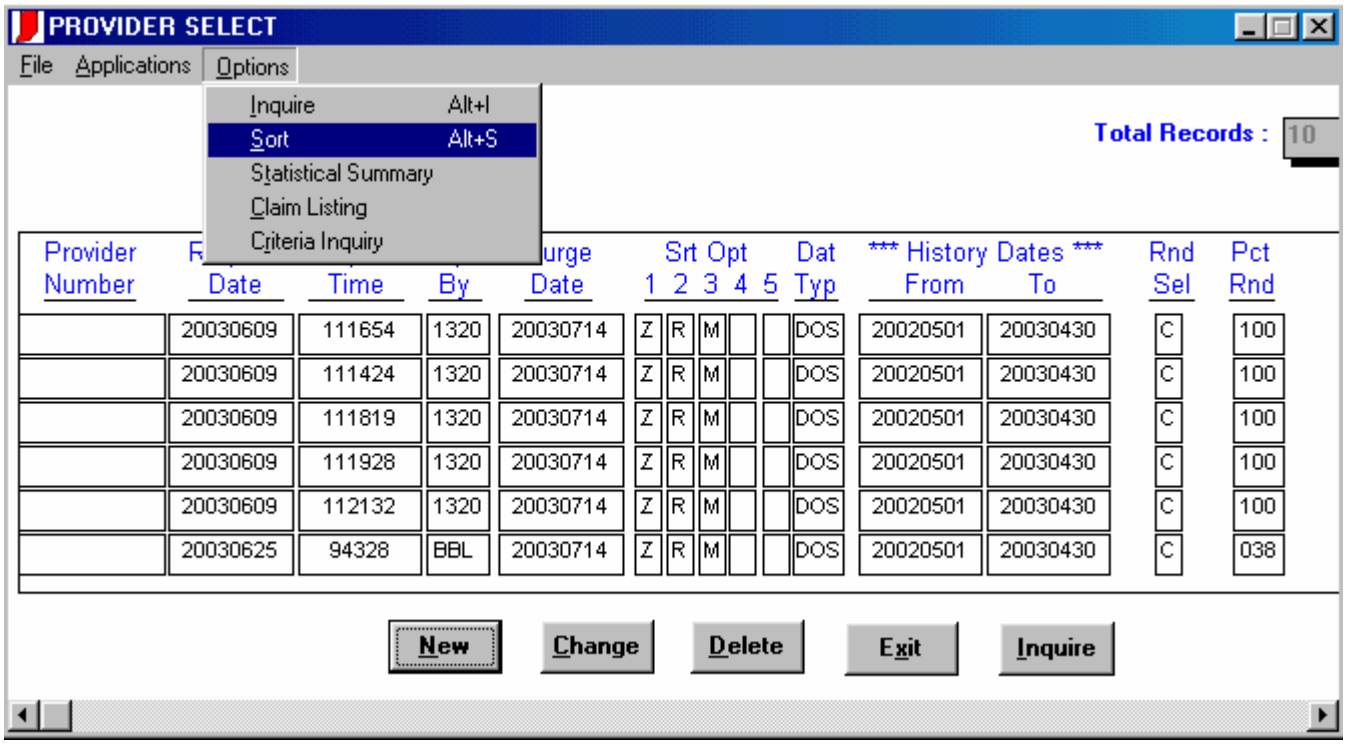
(5) Key in the provider number and press Enter. The demographic information is automatically populated.
(6) Enter 1320 in the Operator ID field.
(7) Tab to the Date Range field. Select Date of Service from the drop-down menu.
(8) Tab to the next field. Enter the From and To Date of Service (Usually a fifteen-month period is utilized.) Enter as YYYYMMDD (ex. 20020101).
(9) Tab to the Sort Order fields. There are five Sort Order Fields. Each field has a drop-down menu, options are: Admit Date, Age, Attending Physician, Category of Service, Claim Charge, Claim Paid Detail Charge, Detail Allowed Diagnosis Code, Dispense Date, DOP, DOS, DRG, Drug Class, Drug Code, EOB, ICN, Nursing Home Code, Prescribing Physician, Procedure/Modifier Code, Recipient Name, Referring Physician, Revenue Code, and RID. Usually the first field is Recipient Name, the second field is ICN, and the third field is DOS, however this order may vary based on SUR Reviewer preference.
(10) Enter 100% in the % Claims field.

(11) The report can be filtered further if specific claim review is necessary. If so, tab to the filter fields. There are five filter fields, each one with a drop-down menu. Choose Admit Date, Age, Attending Physician, Category of Service, Claim Charge, Claim Paid, Detail Charge, Detail Allowed, Diagnosis Code, Dispense Date, DOP, DOS, DRG, Drug Class Drug Code, EOB, Lock-in Indicator, Nursing Home Code, Prescribing Physician, Procedure/Modifier Code, Referring Physician, Revenue Code, and RID for any of the five filter fields.

(12) Select Save. Save is confirmed with Save Successful message.

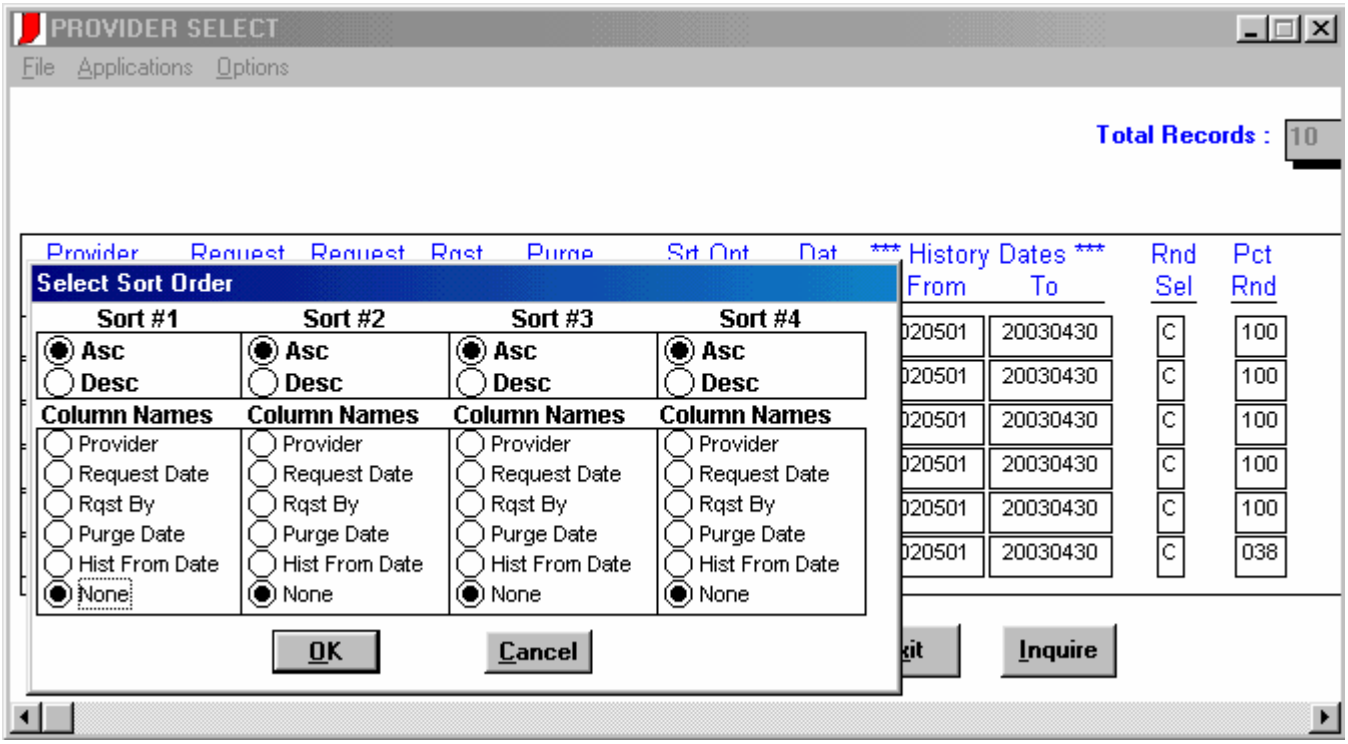
i. Ordering the SUR 1320 hardcopy

FIGURE IV – 32
PROVIDER SELECT



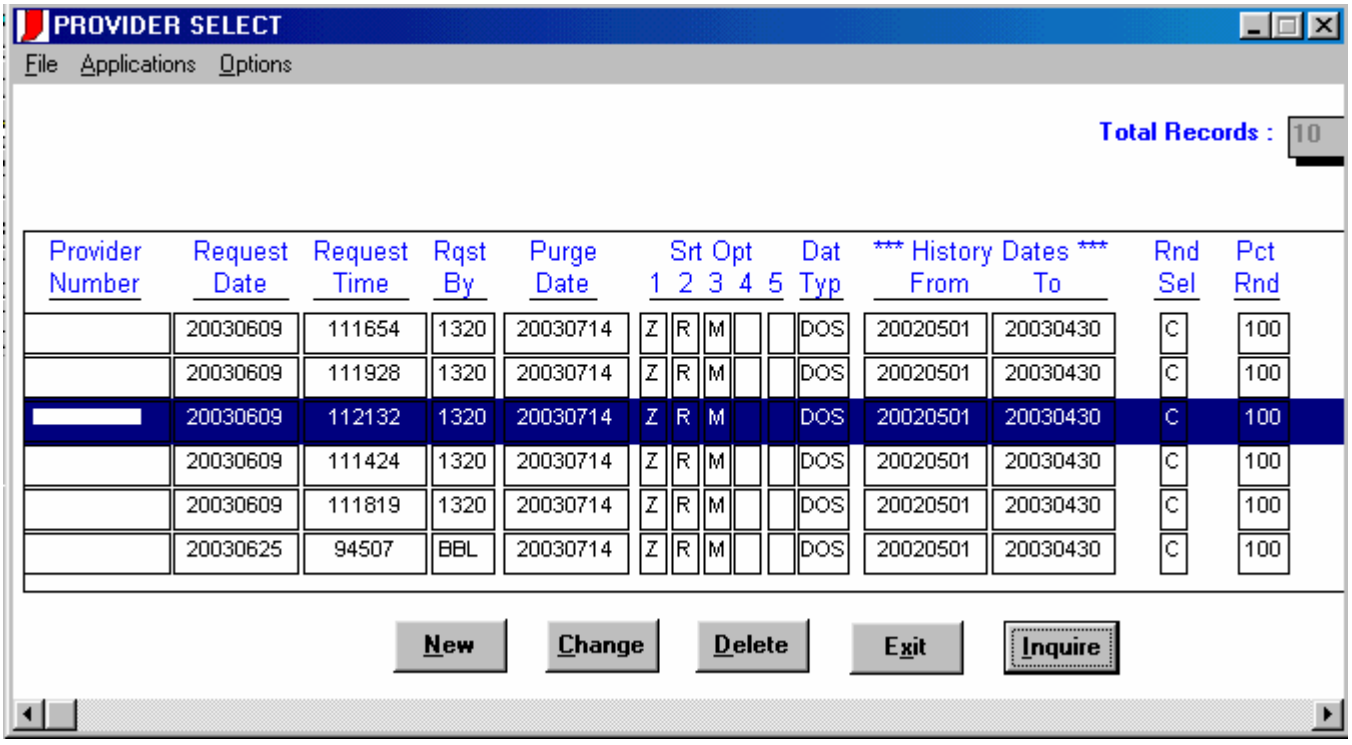
(1) Exit to the Provider/History Sample screen.
(2) Select Options-Sort.

FIGURE IV – 33
SELECT SORT ORDER



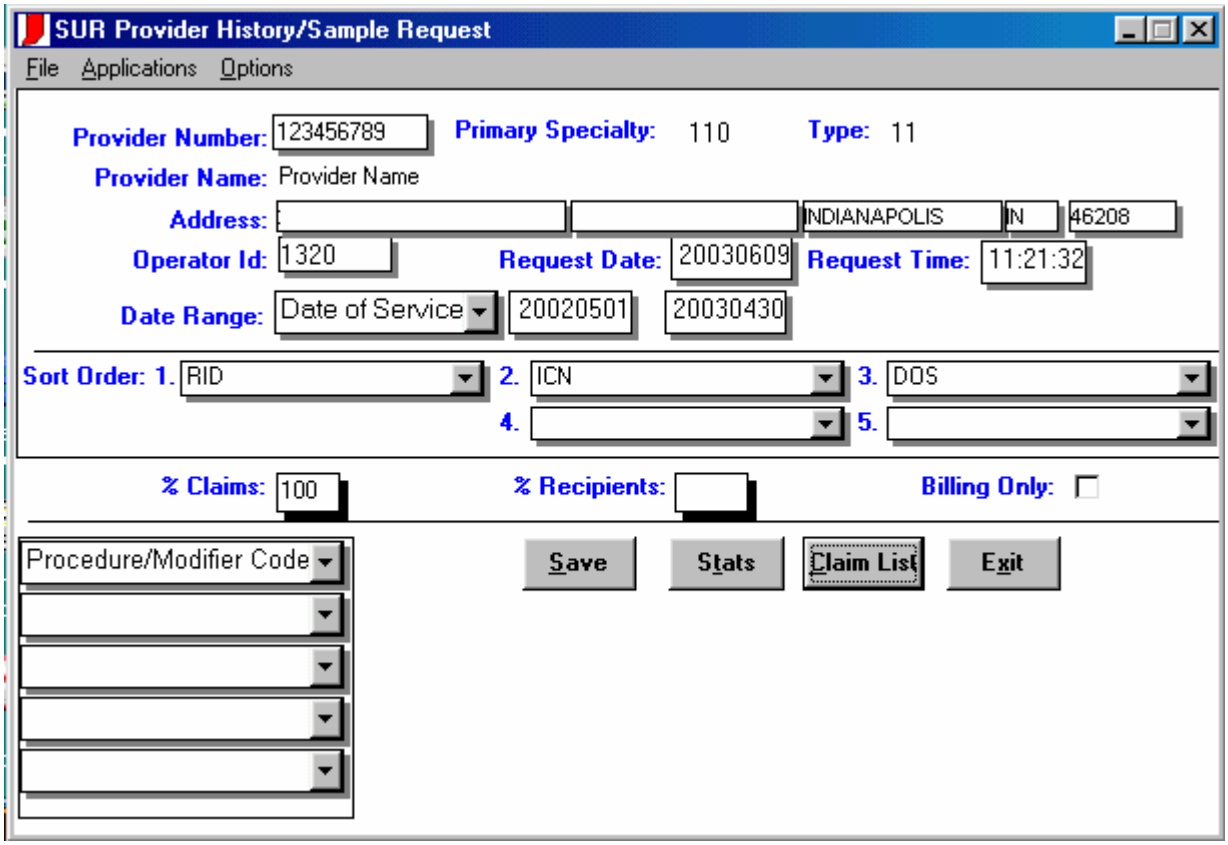
(3) Sort the reports as needed to locate the desired report.

FIGURE IV – 34
PROVIDER SELECT



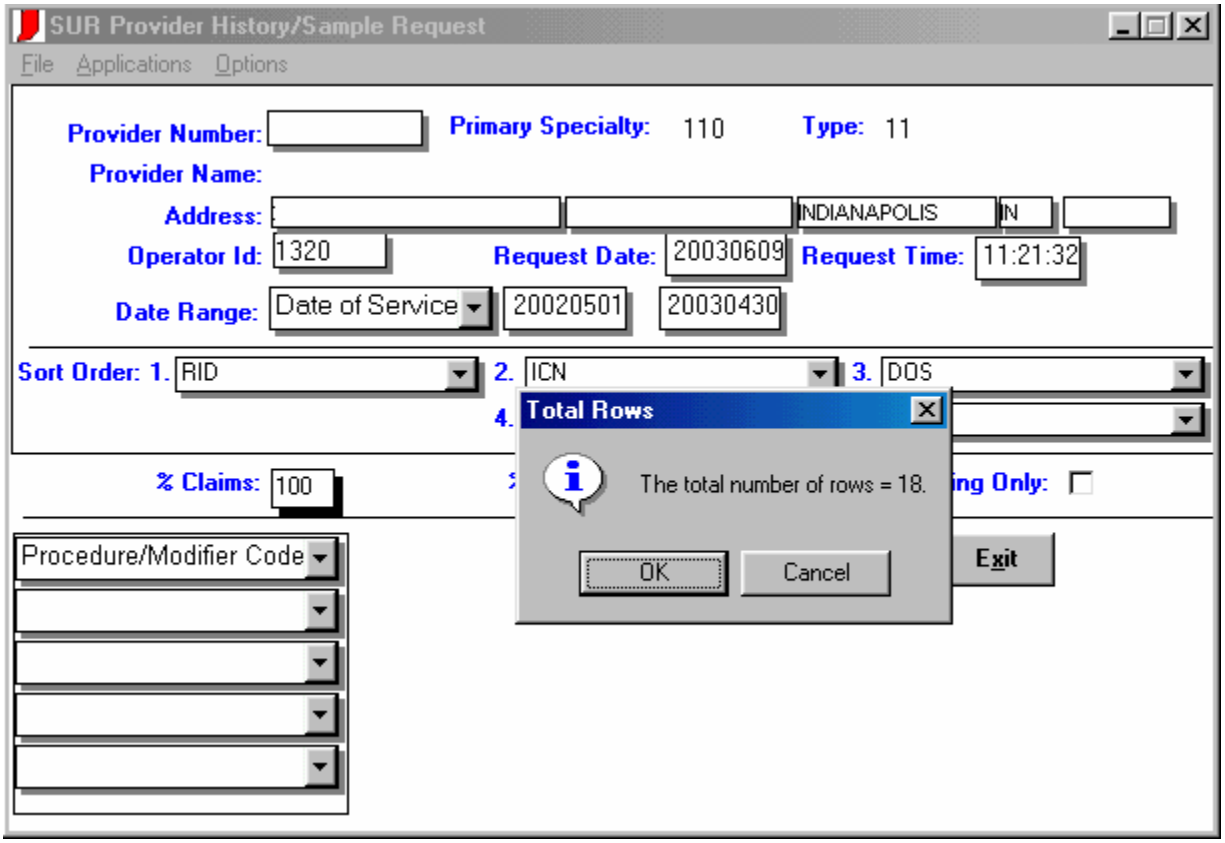
(4) Select the desired report that is needed in hardcopy form.
(5) Choose Inquire.

FIGURE IV – 35
SUR PROVIDER HISTORY/SAMPLE REQUEST



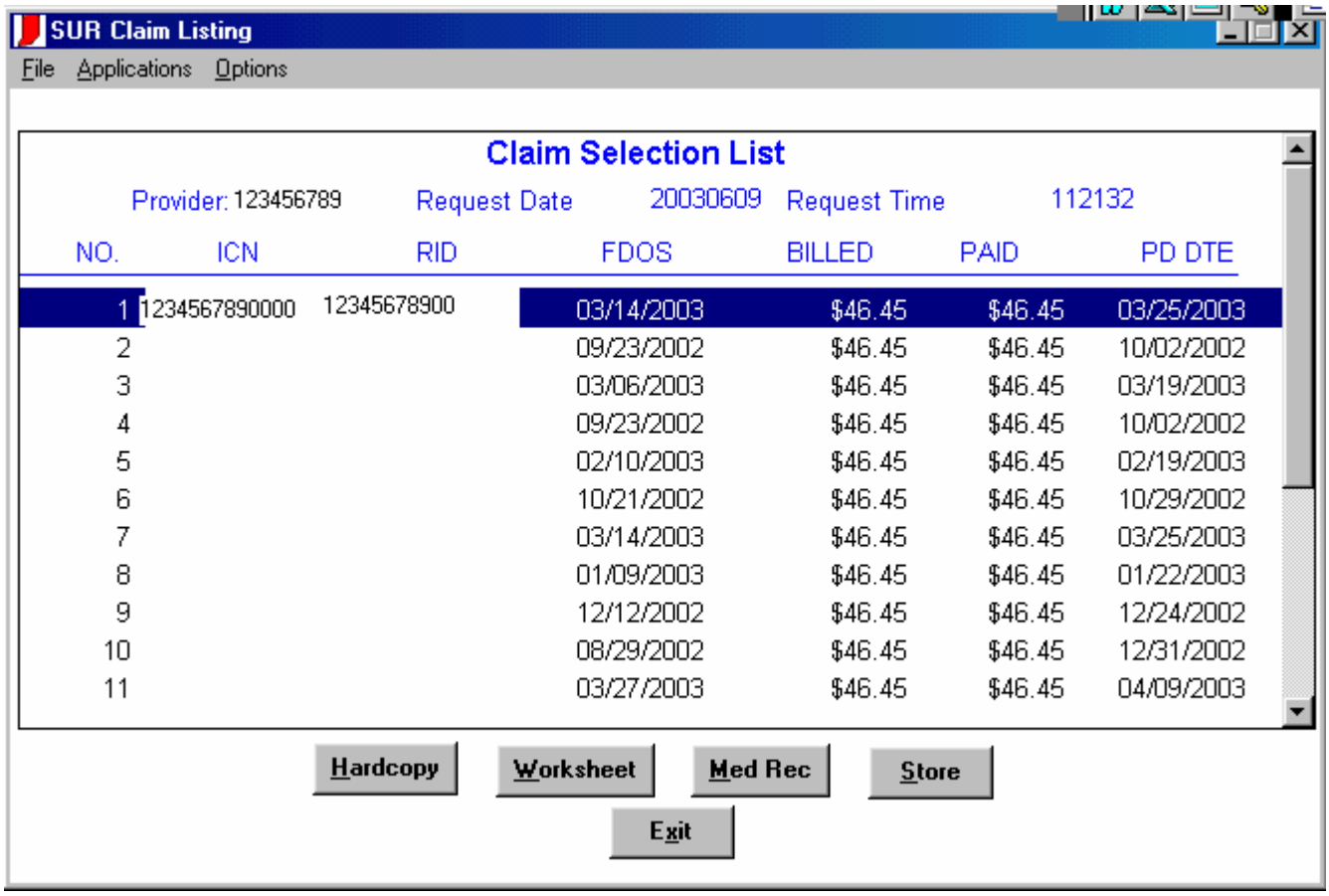
(6) Select Claim List.

FIGURE IV – 36
SUR PROVIDER HISTORY/SAMPLE REQUEST TOTAL ROWS



(7) A screen showing the total number of rows will appear. Select OK.

FIGURE IV – 37
SUR CLAIM LISTING



(8) Choose Hardcopy.
(9) Exit the SUR Claim Listing.
(10) The following day the SUR Reviewer enters CO-MAND to retrieve the 1320. See Figure IV-3. Enter SUR1300DO to locate the report and print.
(11) After receiving the 1320 and determining the total number of Medicaid claims to be reviewed, the SUR Reviewer can order a Provider Detail Report to see sample of paid claims details. This report is called a PDR or SUR 1300 report.

j. Ordering a SUR 1300, Provider Detail Report
(1) Return to Provider/History/Sample and complete steps 3-8 on pages 111 through 113.
(2) Enter the percentage utilizing a decimal format (e.g. 52% =0.52) in the Percentage Claims field for the minimum random sample of claims required.

Formula: $\frac{\text{number in random sample}}{\text{Total number in universe}} \times 100$

(3) The report can be filtered further if desired by utilizing the five Sort Order fields as previously described.
(4) Select Save. Save is confirmed with Save Successful message.

k. Ordering a Hardcopy SUR 1300 Provider Detail Report
(1) Return to Provider/History/Sample and complete steps 2-10 on pages 111 through 113.
(2) When exiting the SUR Provider History/Sample Request screen DO NOT SELECT SAVE, only exit.

l. Completion of the Off-site Desk Review
(1) Conduct a review of the claims sample.
i. This review should include research of billing and coding guidelines both general and specialty specific to ensure compliance.
ii. The review should also focus on provider utilization and appropriateness of utilization.
iii. General guidelines include discrepancies such as
a.) duplicate billing
b.) diagnoses not supportive of the services provided
c.) inappropriate use of modifiers
d.) services provided after the member's date of death
e.) quantity of services provided
f.) inappropriate diagnosis and procedure code use
g.) dates of service prior to provider enrollment date
h.) inappropriate number of units billed
i.) billing services outside of normal provider specialty

(2) Enter the data gathered from the reports and claim review and supply the findings following the Off-site Desk Review template. See **EXHIBIT IV- 6**.

(3) Based on the findings, the SUR Reviewer determines a case recommendation.
i. On-site Audit
a.) serious billing concerns are noted
b.) services being provided require special equipment
c.) provider location is questionable
d.) referral issue would require verification by on-site
ii. Door Knock Audit
a.) provider is newly enrolled
b.) a small number of billing concerns
c.) verification of provider location and services is warranted
iii. Medical Record Request
a.) small number of claims are involved in the audit
b.) a follow up audit is being performed where no serious concerns are noted
c.) a specific issue is noted and full on-site audit of claims is not required
iv. Case Closure

a.) no concerns noted in the off-site review
b.) provider appears to be in compliance with IHCP guidelines

v. Provider Education
   a.) one or two small concerns not resulting in significant overpayment
   b.) issue appears to be provider ignorance

vi. Referral to MFCU or other agency
   a.) serious concerns are noted where intent appears to be present
   b.) provider is completely non-compliant with IHCP guidelines.

m. Other
   (1) Route the off-site desk review to the SUR Supervisor for review and approval.
   (2) Case is routed to SUR Director, Program Director, and Medical Director for approval.
   (3) Present the off-site desk review in the weekly SUR department meeting for management approval.

n. MFCU Review
   (1) Route the provider name, number and case recommendation to the SUR Secretary for addition to the weekly MFCU release letter. See **EXHIBIT IV – 7**. Note the tracking number on the letter.
   (2) MFCU release or approval is confirmed via a letter or e-mail from the Director of MFCU referencing the tracking number on the release letter.
   (3) If the letter is returned referencing a hold for a specific provider, all further SUR action for that provider is suspended. The case remains on MFCU hold until further action is approved in writing. When release is granted, proceed with the recommended case action.
   (4) Once the off-site desk review recommendation is approved and MFCU release is received, the SUR Reviewer may proceed with the recommended action.

EXHIBIT IV – 6
OFF-SITE DESK REVIEW

Health Care Excel
Indiana Medicaid Medical Policy and Review Services

PROVIDER OFF-SITE REVIEW

REVIEWER: **LEVEL I:** 00/00/00
REVIEW PERIOD: **LEVEL II:** 00/00/00

A. PROVIDER DATA

Name: Provider Name **Medicaid Provider ID:** #########
Address: Street
City, ST 00000
Phone: (000) 000-0000

COS: 00 (description)
Specialty: 000 (description)
Type: 00 (description)

B. GENERAL DATA:

1. REASON FOR REVIEW:
State why this provider was chosen for review. If the review is a result of a referral, state the issues involved and the source of the referral.

2. EXCEPTION RANKING(S):
Summary Profile: *ranking from the Co-Mand SUR3300*
Treatment Analysis:
Other:

3. MEDICAID DOLLARS PAID *(information from MARS)*

2003 YTD	$	$	as of Month/current year
2002	$		
2001	$		

4. SCREENING CRITERIA:
(This information is from the Co-Mand SUR3200/3210 report. Always report the statistics from lines 5, 6, 7, and 8. The provider/PGA ratio is determined by dividing the average amount for each line by the peer group average for that line.)

EXHIBIT IV – 6
OFF-SITE DESK REVIEW (Continued)

Health Care Excel
Indiana Medicaid Medical Policy and Review Services

PROVIDER OFF-SITE REVIEW

No	LINE ITEM	PROVIDER	PGA	PROVIDER/PGA RATIO
#5	NumberMedicaid Recipients			
#6	Avg. Amt Billed/ Recipient			
#7	Avg. Amt Paid/ Recipient			
#8	Avg. No. Svc/Recipient			

C. SUMMARY OF PREVIOUS REVIEWS

Check the SURS database for previous reviews. If no previous reviews found, state "No previous reviews were located in the Health Care Excel files for this provider."

D. REVIEW PERIOD DATA

1. STATISTICAL PATTERN PROBLEMS

Explain. Give narrative or indicate "Not applicable."

2. STATISTICAL DIFFERENCES (NOT PATTERN PROBLEMS)

No.	LINE ITEM	PROVIDER	PGA	PROVIDER/PGA RATIO

(Include lines from the CO-MAND SUR3200/3210 report that shows either high or low utilization as compared to the Provider/PGA Ratio)

3. NON-STATISTICAL PATTERN PROBLEMS

Explain. Give narrative or indicate "None noted."

E. SUMMARY OF DATA ANALYSIS

F. RECOMMENDATIONS

Describe recommendation.

On-site audit to:

- Review Medical Records for support of claims submitted.
- Recoup inappropriately paid monies, if applicable.
- Educate the provider, where appropriate, regarding submission of future claims.

EXHIBIT IV – 6
OFF-SITE DESK REVIEW (Continued)

Health Care Excel
Indiana Medicaid Medical Policy and Review Services

PROVIDER OFF-SITE REVIEW

_____	_____
Reviewer Name SUR Reviewer	Date
_____	_____
SUR Supervisor	Date
_____	_____
SUR Director	Date
_____	_____
Medical Director	Date

EXHIBIT IV – 7
MFCU RELEASE LETTER

Date

Tracking No:

Office of the Attorney General
Medicaid Fraud Control Unit
8005 Castleway Drive
Indianapolis, Indiana 46250-1946

RE: SUR Review Activity

Dear :

The following is a list of providers for whom Surveillance and Utilization Review (SUR) would like to proceed with specific recommendations. One category of recommendation referenced below is Recoupment or Education. This recommendation represents those providers for whom SUR has completed an audit and is prepared to send out a recoupment or educational letter. The second category of recommendation is on-site audit or medical record audit at Health Care Excel (HCE). For these cases, SUR is planning to perform an audit of the provider – either by visiting the provider's location (on-site) or by requesting that the provider send copies of the supporting documentation to the HCE office (medical record audit at HCE).

The SUR Department has logged these reviews and will hold any further action in abeyance until the MFCU responds within the agreed upon ten (10) day time frame. If no response is received within that time frame, the SUR Department staff will proceed with the recommended action, unless the OMPP has directed otherwise.

Provider Name	**Provider Number**	**Recommendation**

Should you have any questions or concerns regarding these cases, please contact me directly at (317)-347-4500 extension 248.

EXHIBIT IV – 7
MFCU RELEASE LETTER (Continued)

Sincerely,

Director of Surveillance and Utilization Review

cc: OMPP Policy Analyst-SUR
Program Director of Acute Care Operations, OMPP
Secretary of Acute Care Operations, OMPP
SUR Supervisors, Health Care Excel
Director of Program Operations, Health Care Excel

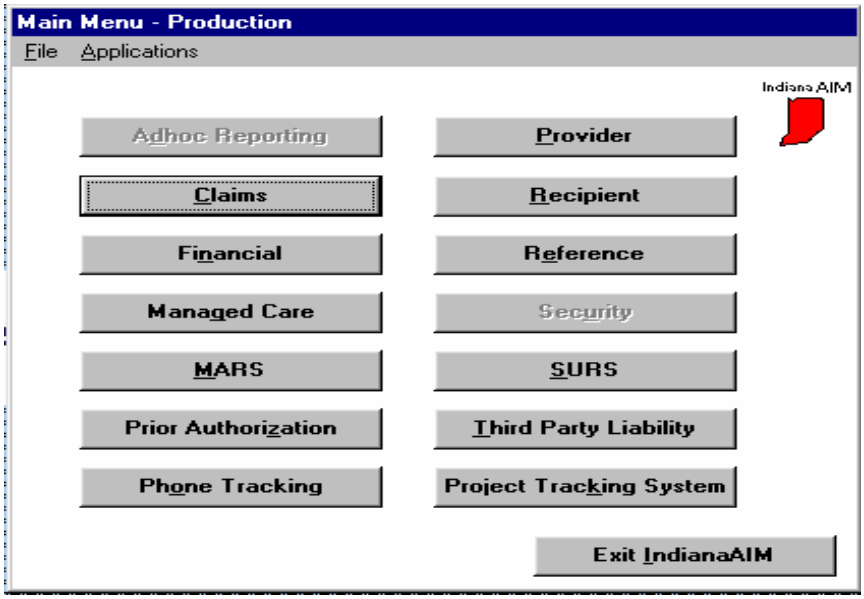
o. On-site or Medical Record Request Audit

The following procedure outlines the steps required to select claims and prepare for an on-site or medical record request audit of a hospital or acute care facility.

FIGURE IV – 38
INDIANA AIM LOGON

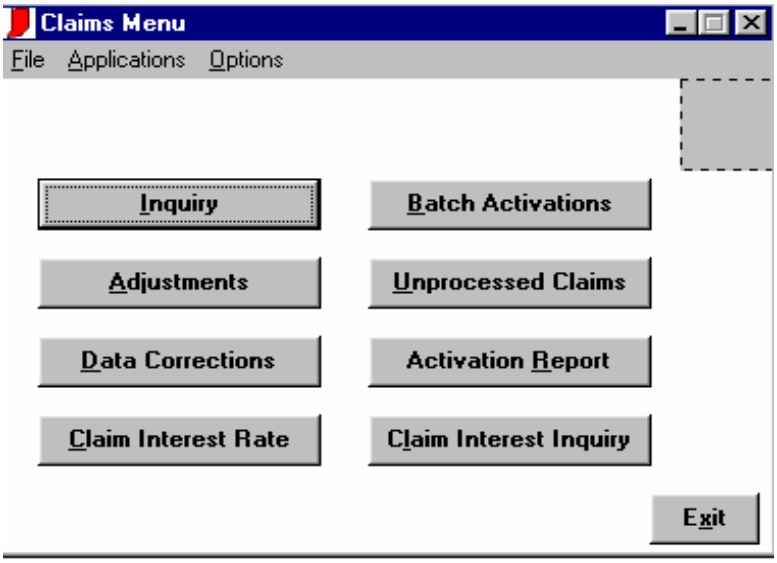
(1) Logon to Indiana*AIM*.

FIGURE IV – 39
MAIN MENU



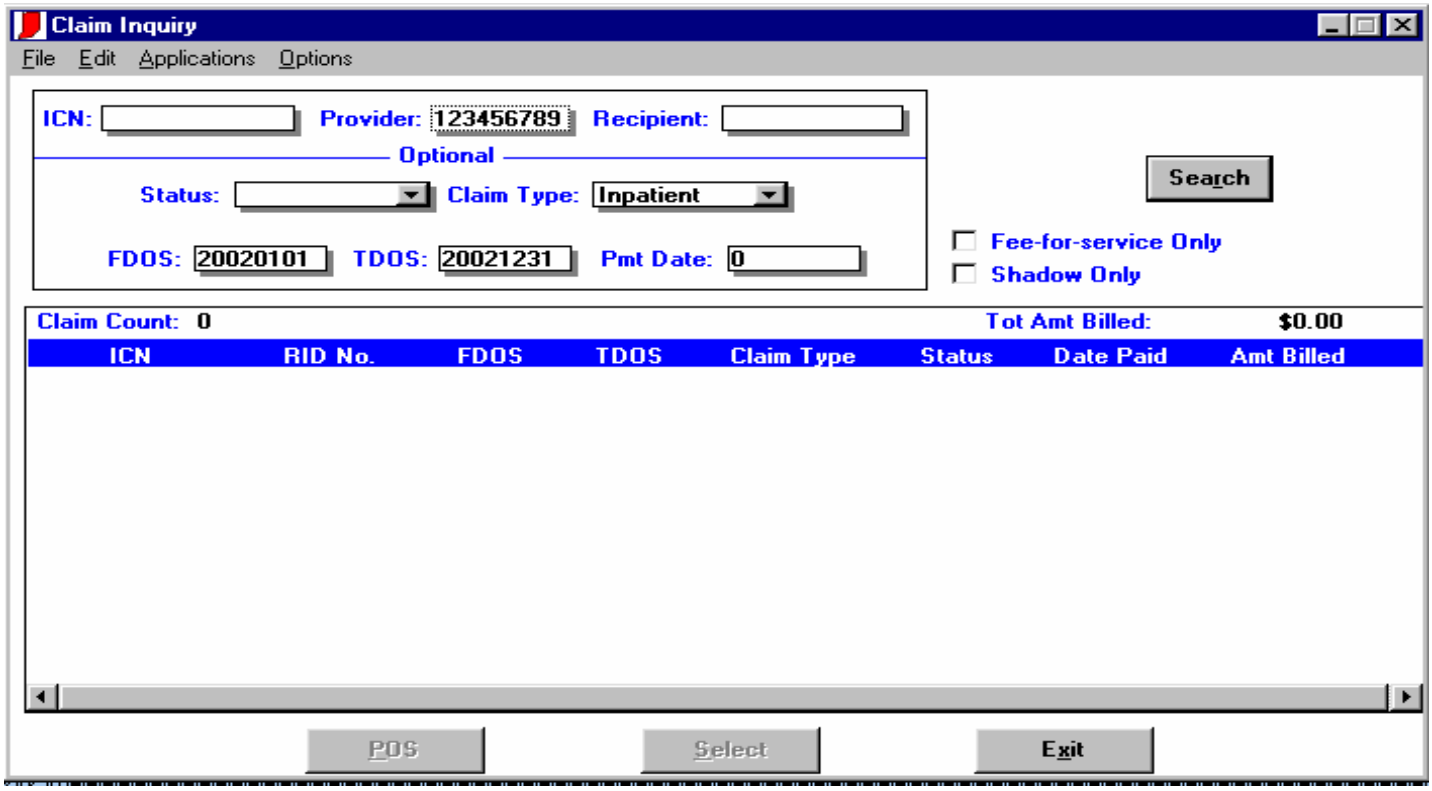
(2) Select Claims.

FIGURE IV – 40
CLAIMS MENU



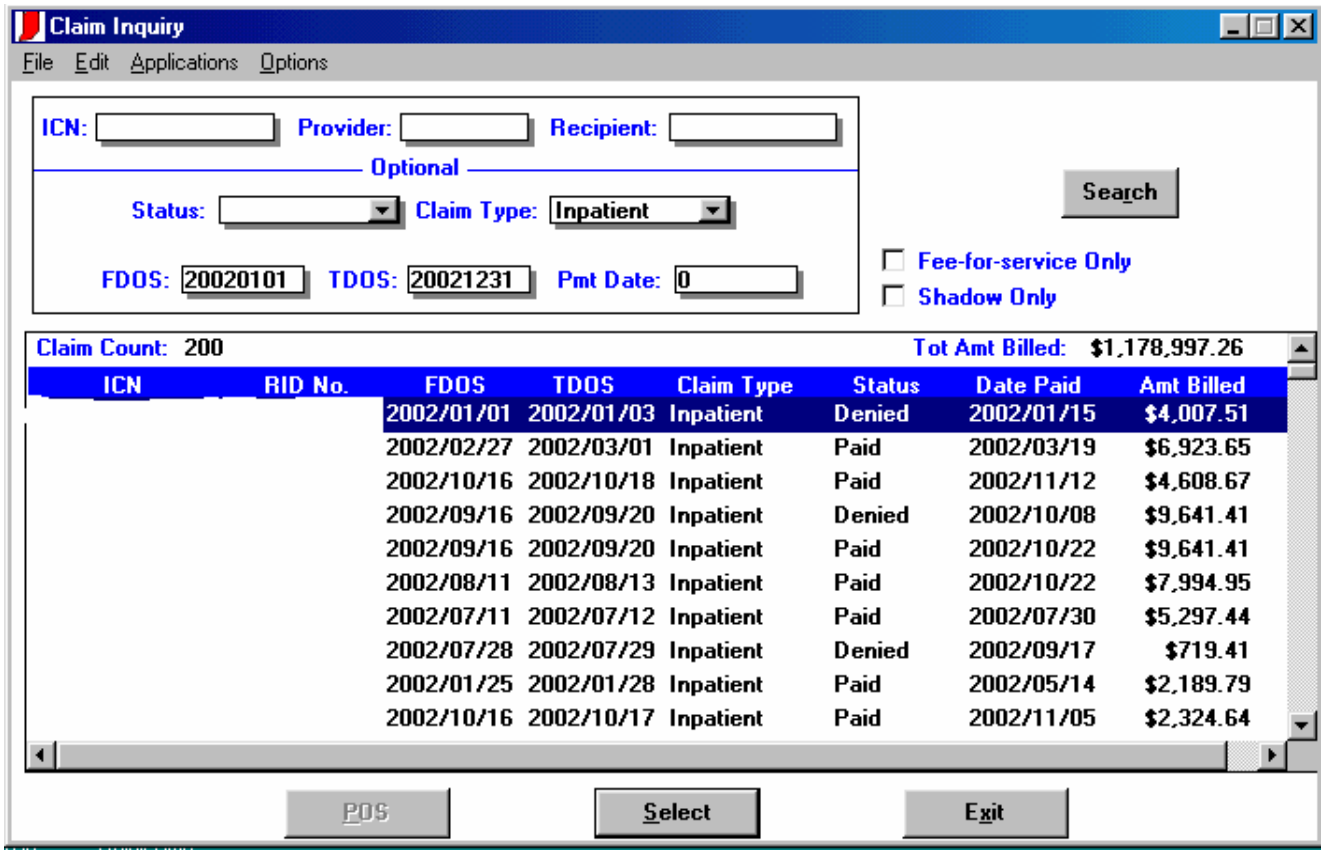
(3) Select Inquiry.

FIGURE IV – 41
CLAIM INQUIRY



(4) Enter the provider number for review.
(5) Go to claim type and select inpatient from the drop down menu; also, go to status and select paid from the drop down menu.
(6) Enter the dates of service outlined in the off-site desk review in the YYYYMMDD format in the FDOS and TDOS fields. The SUR Reviewer may utilize different dates of service than those listed in the off-site desk review based on the off-site findings.
(7) Select Search.

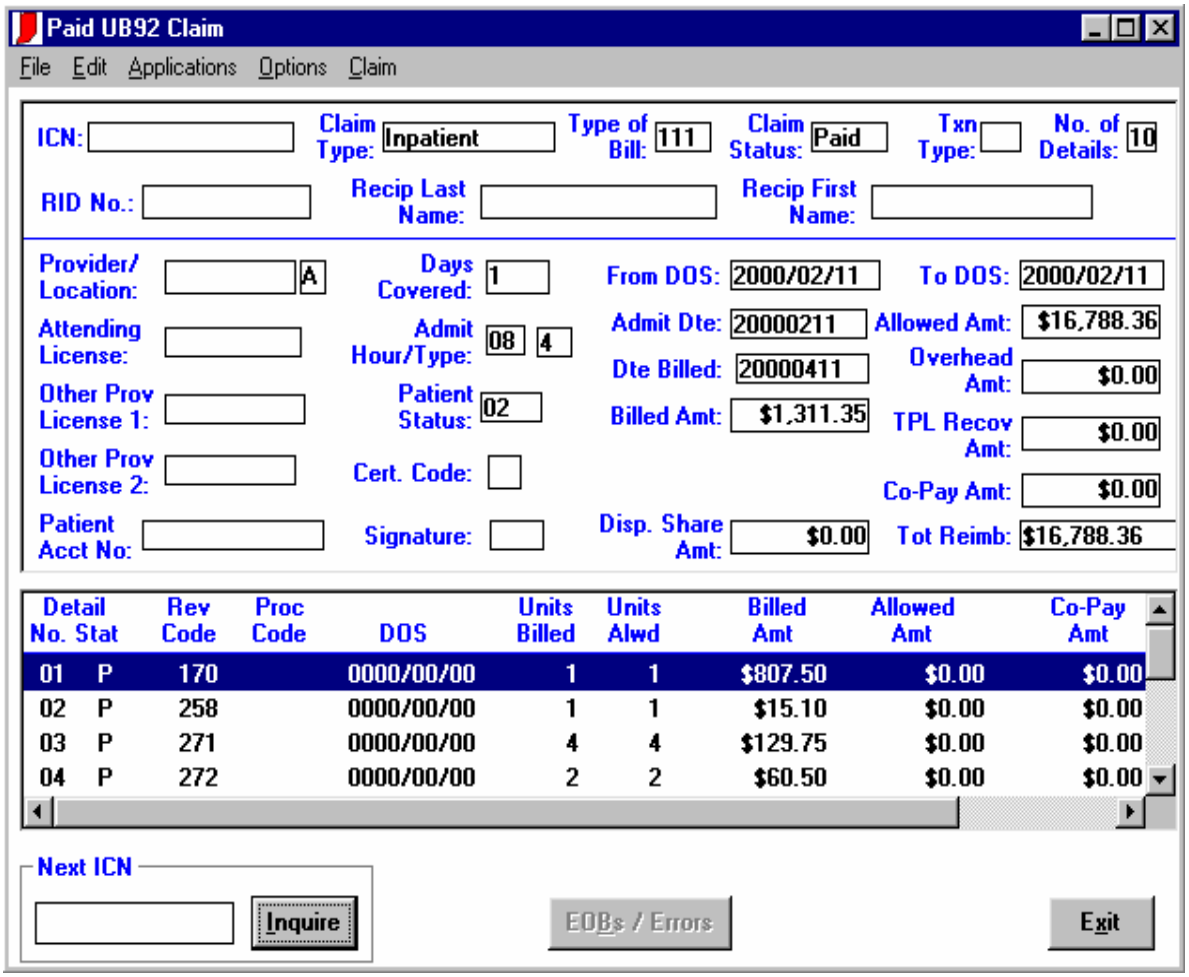
FIGURE IV – 42
CLAIM INQUIRY



(8) Print the generated inpatient claims list by selecting Print Window-Data Window.
(9) Review the inpatient claims list for billing and/or coding discrepancies based on rules, regulations and established guidelines. This may include problematic areas such as:
   i. one-day stays for appropriateness of inpatient versus observation status;
   ii. readmission within 15 days of discharge and,
   iii. overpayments based on the amount paid versus billed containing possible coding errors.

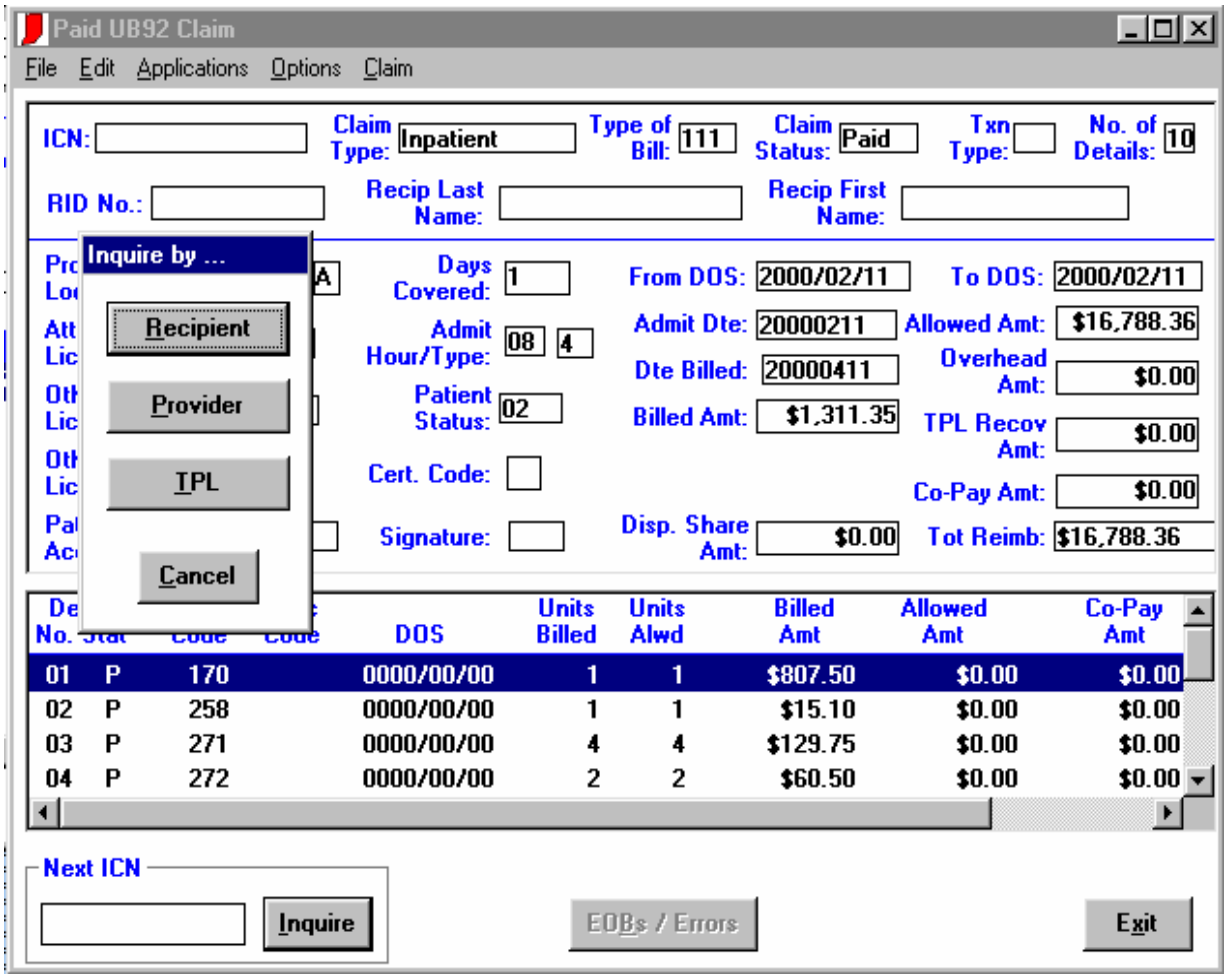
(10) Once claims have been selected for audit, return to the Claim Inquiry screen. See **FIGURE IV – 42**.
(11) Enter the Internal Control Number (ICN) and select Search.

FIGURE IV – 43
PAID UB-92 CLAIM



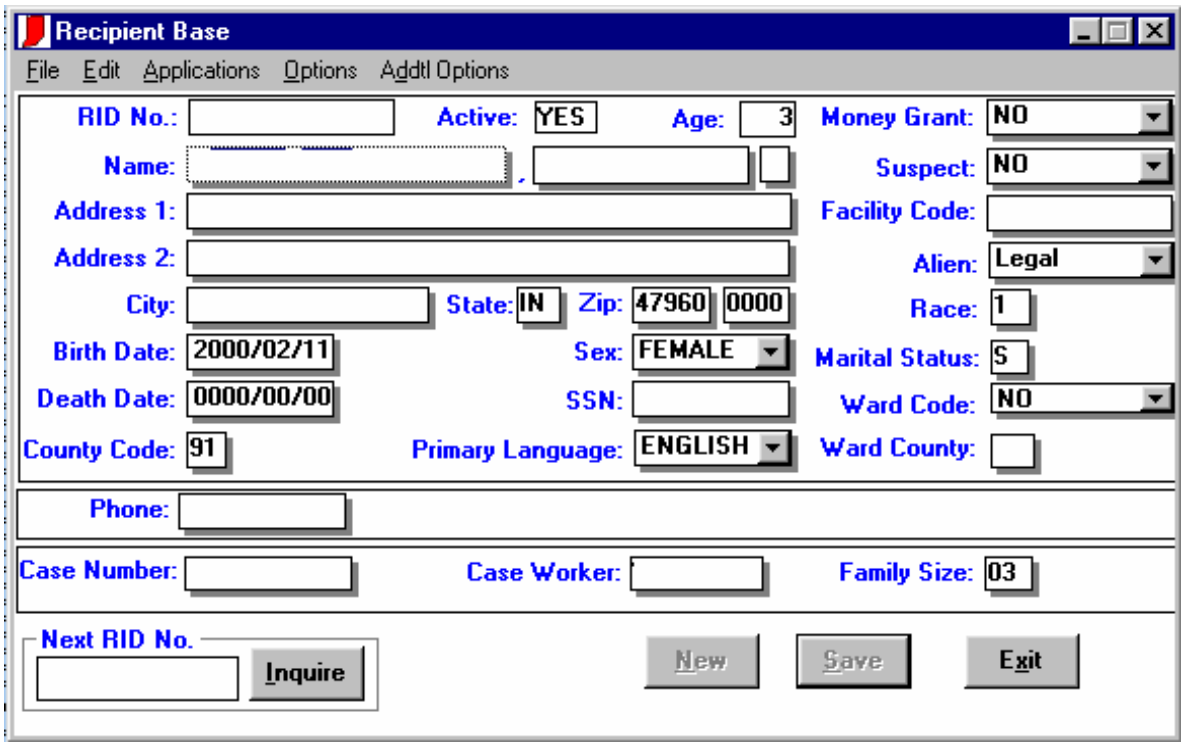
(12) Print the Paid UB-92 Claim screen. This is also referred to as the audit face sheet for inpatient auditing purposes.
(13) Prepare each claim face sheet with the following information: Date of Birth (DOB), diagnoses, procedures, Diagnostic Related Group (DRG) and claim paid date.

FIGURE IV – 44
PAID UB-92 CLAIM



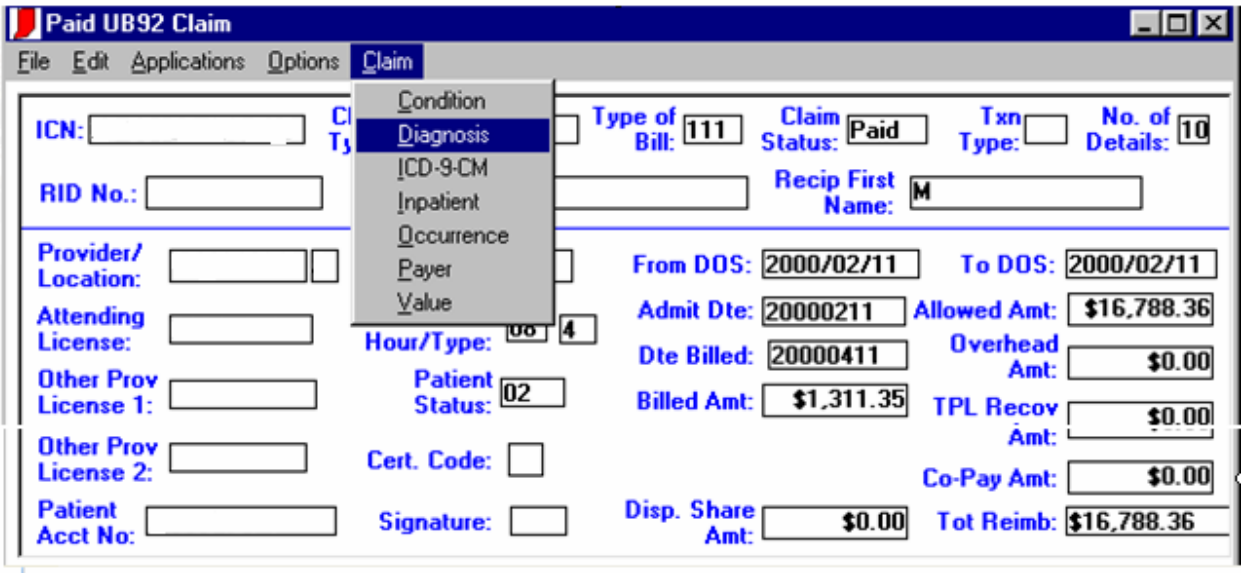
(14) To obtain member DOB, remain in the Paid UB-92 Claim and double click on RID No. The Inquire By window will appear. Select Recipient.

FIGURE IV – 45
RECIPIENT BASE



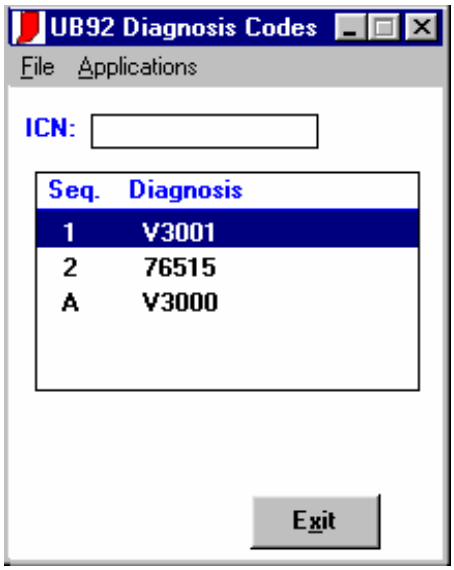
(15) Copy the DOB to the face sheet.

FIGURE IV – 46
PAID UB-92 CLAIM



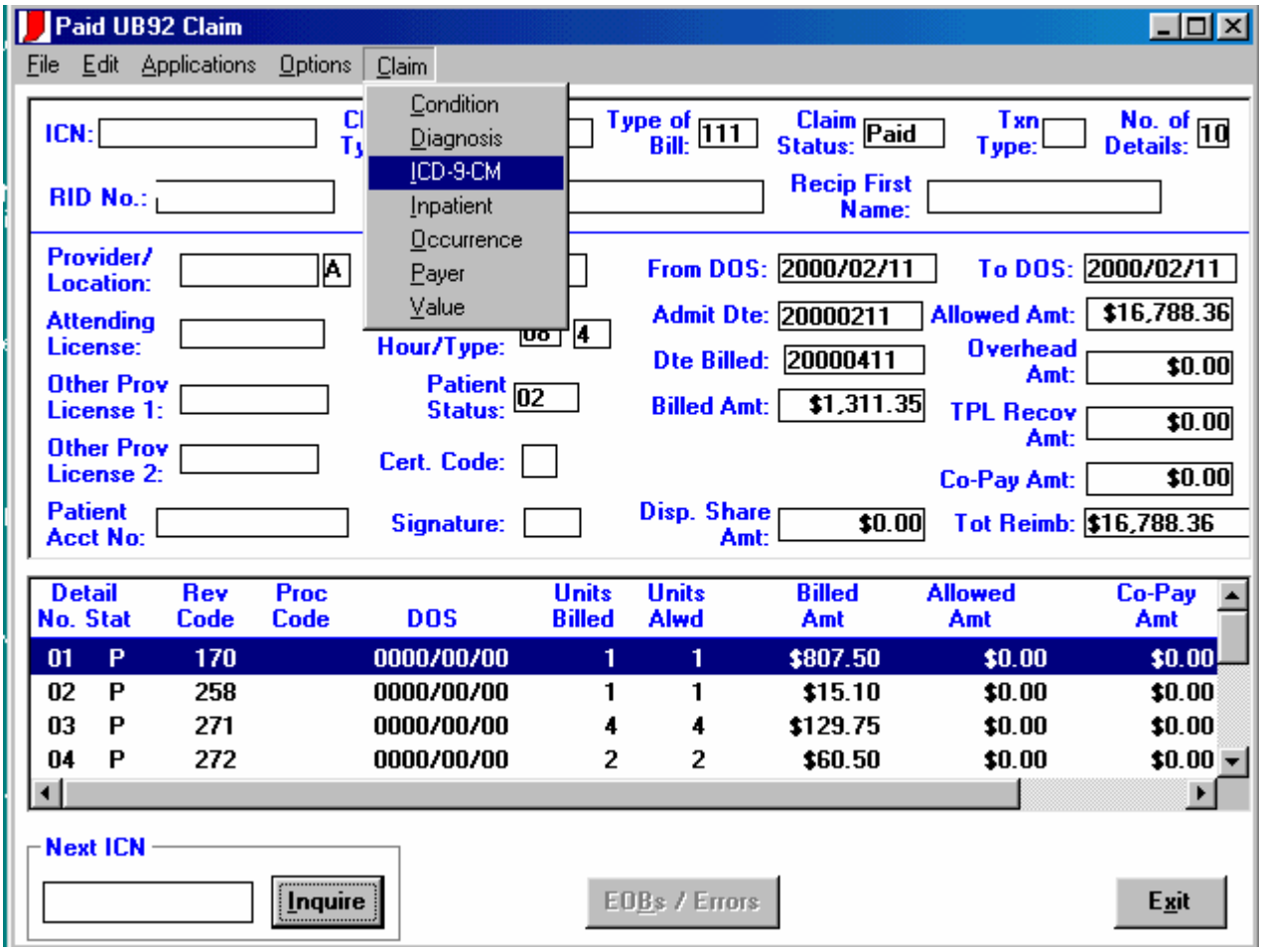
(16) Return to the Paid UB-92 Claim screen and proceed to Claim-Diagnosis to retrieve the diagnoses.

FIGURE IV – 47
UB-92 DIAGNOSIS CODES



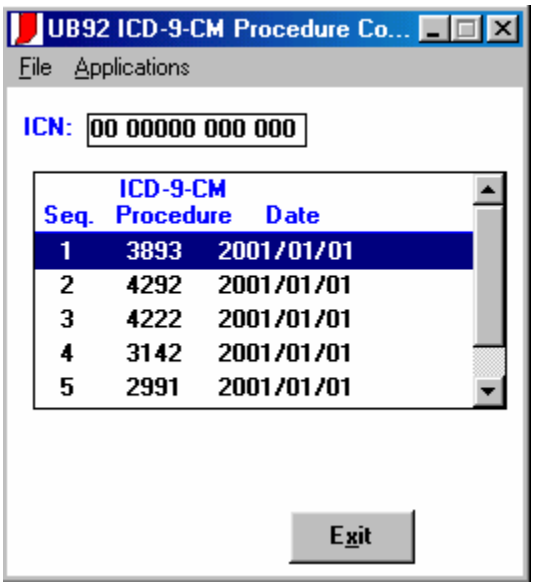
(17) Copy the diagnoses onto the claim face sheet.

FIGURE IV – 48
PAID UB-92 CLAIM



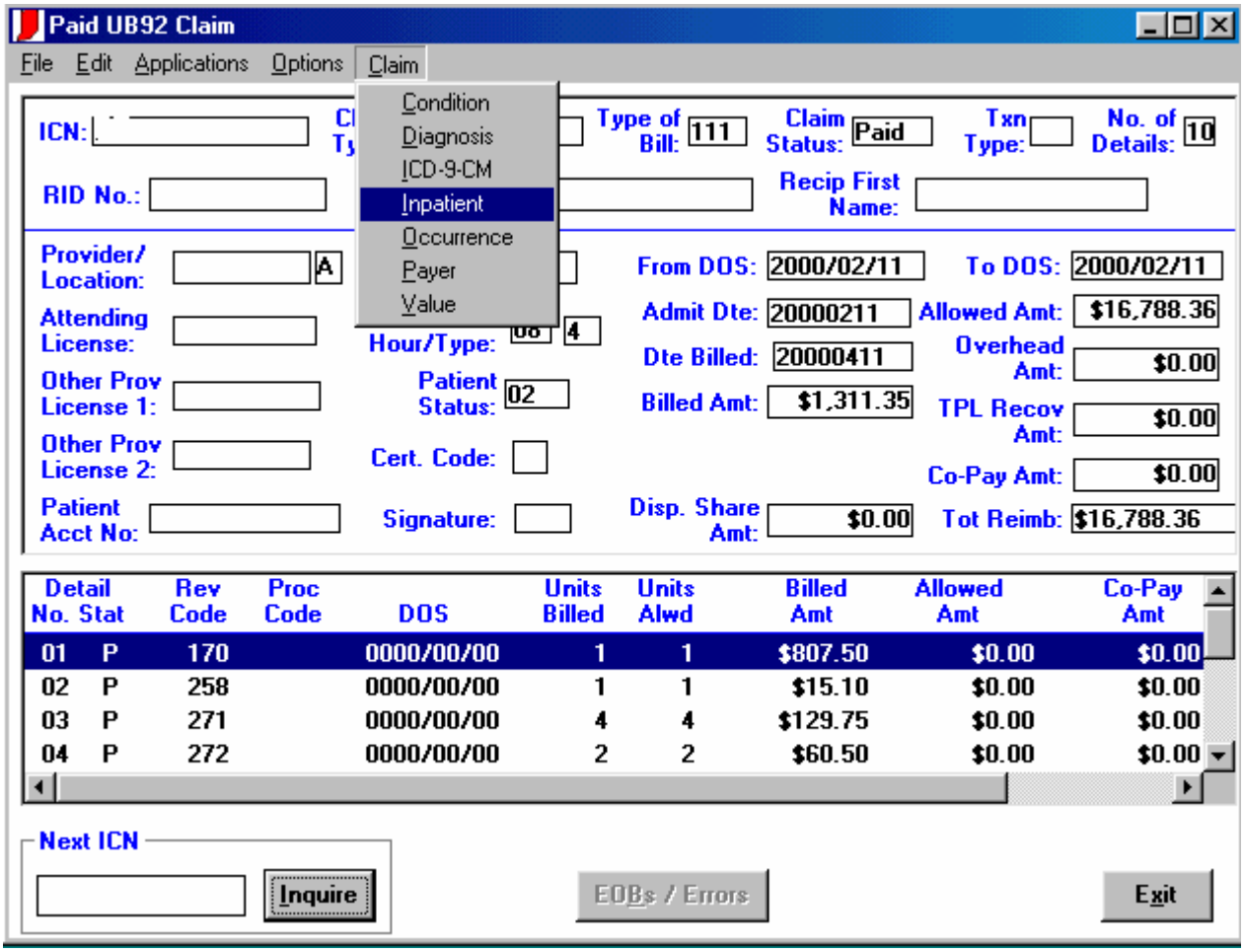
(18) Return to Paid UB-92 Claim screen and proceed to Claim-ICD-9-CM to retrieve the procedure codes.

FIGURE IV – 49
UB-92 ICD-9-CM PROCEDURE CODES



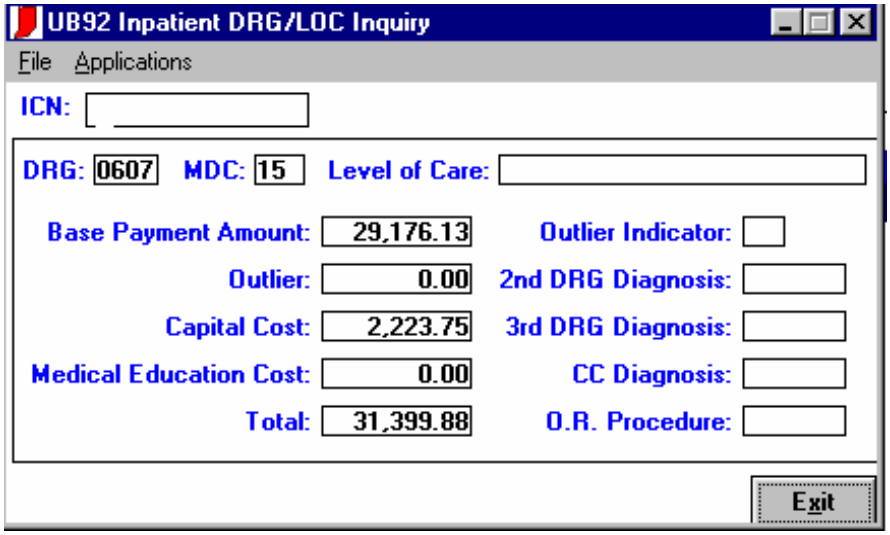
(19) If applicable, copy any procedure codes listed onto the claim face sheet.

FIGURE IV – 50
PAID UB-92 CLAIM



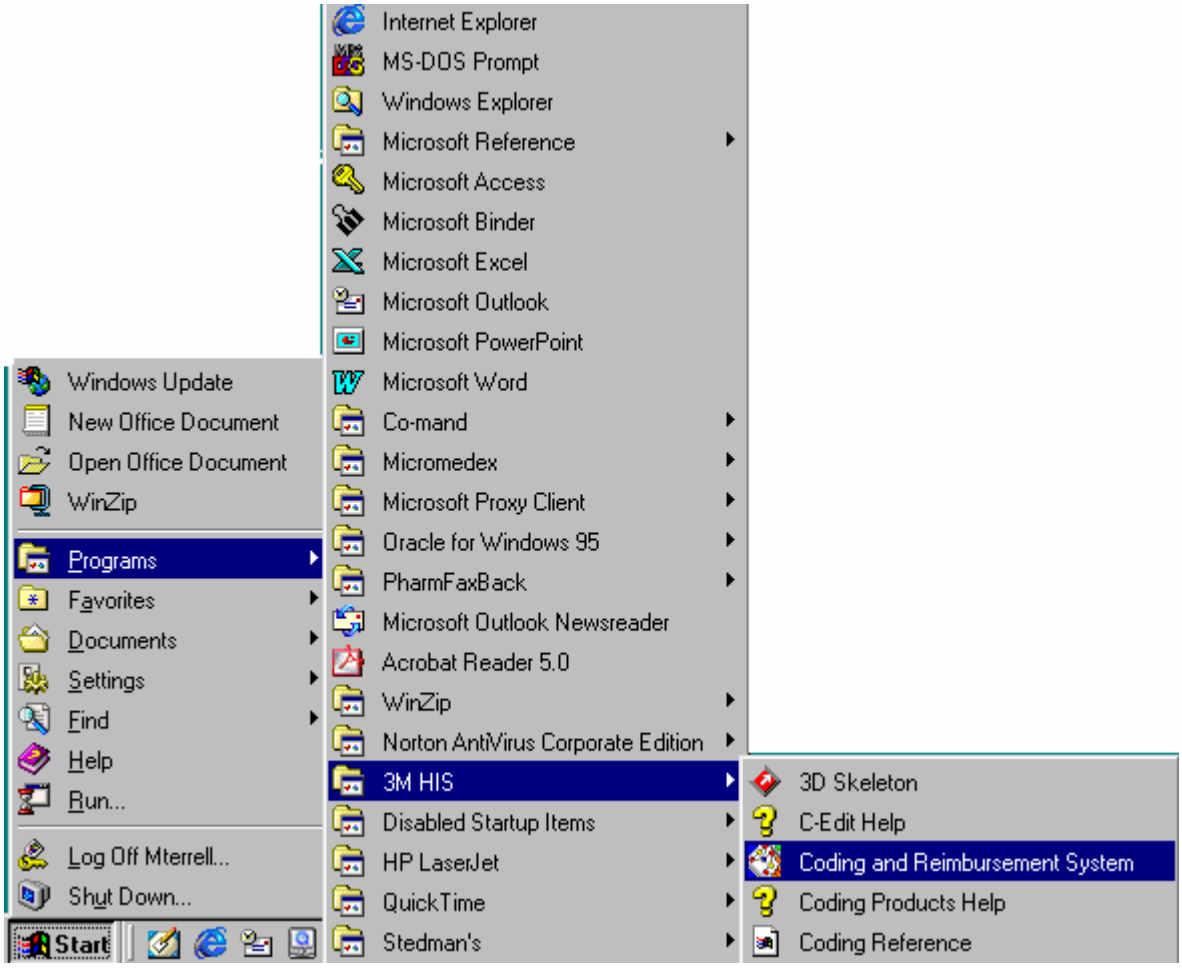
(20) Return to Paid UB-92 Claim screen and proceed to Claim-Inpatient to retrieve the DRG.

FIGURE IV – 51
UB-92 INPATIENT DRG/LOC INQUIRY



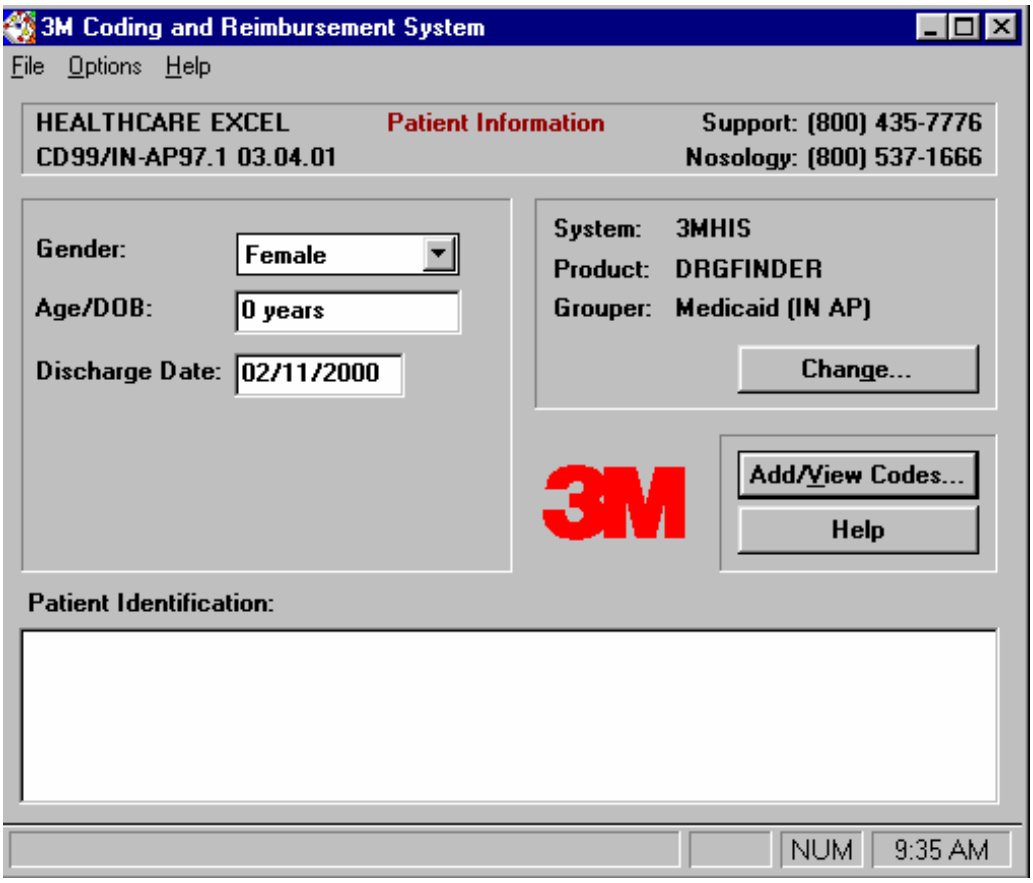
(21) Copy the DRG to the face sheet.
(22) Return to the Claim Inquiry screen to collect the claim paid date. Copy the information to the face sheet and exit Indiana*AIM*.
(23) Match the corresponding PDR sheet to each claim face sheet.

FIGURE IV – 52
PROGRAM MENU



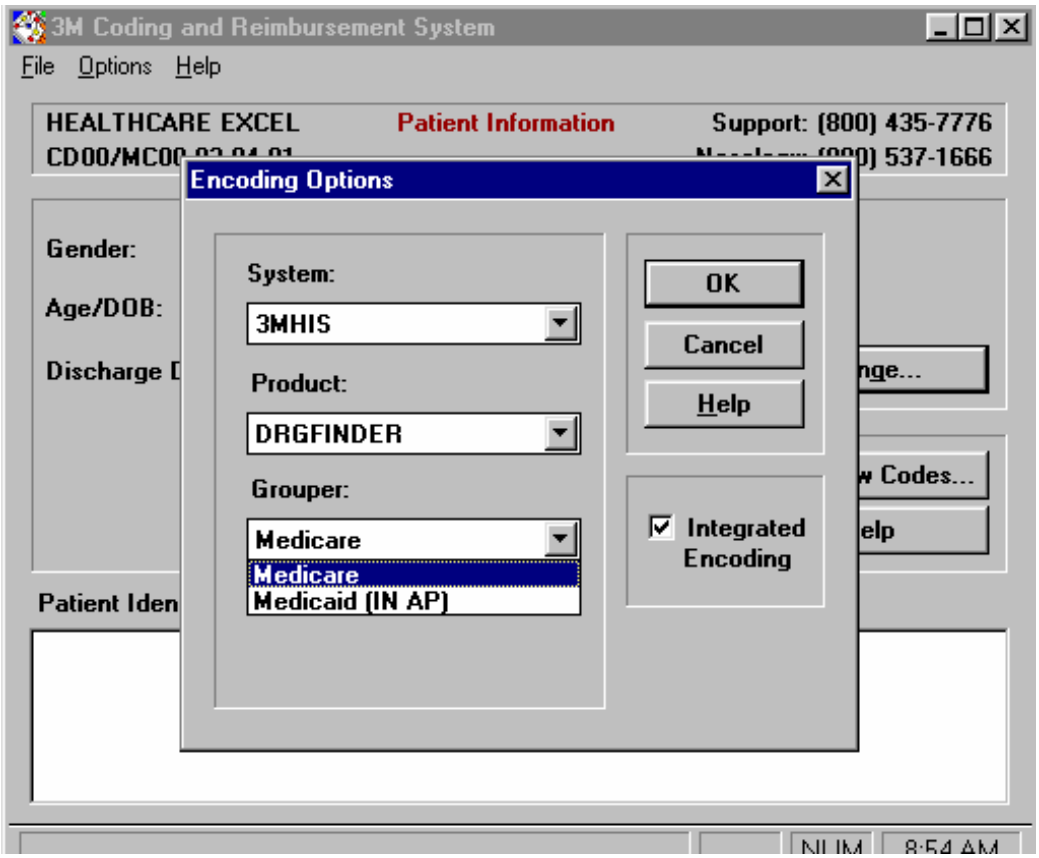
(24) Go to Program-3M HIS-Coding and Reimbursement System.

FIGURE IV – 53
3M CODING AND REIMBURSEMENT SYSTEM



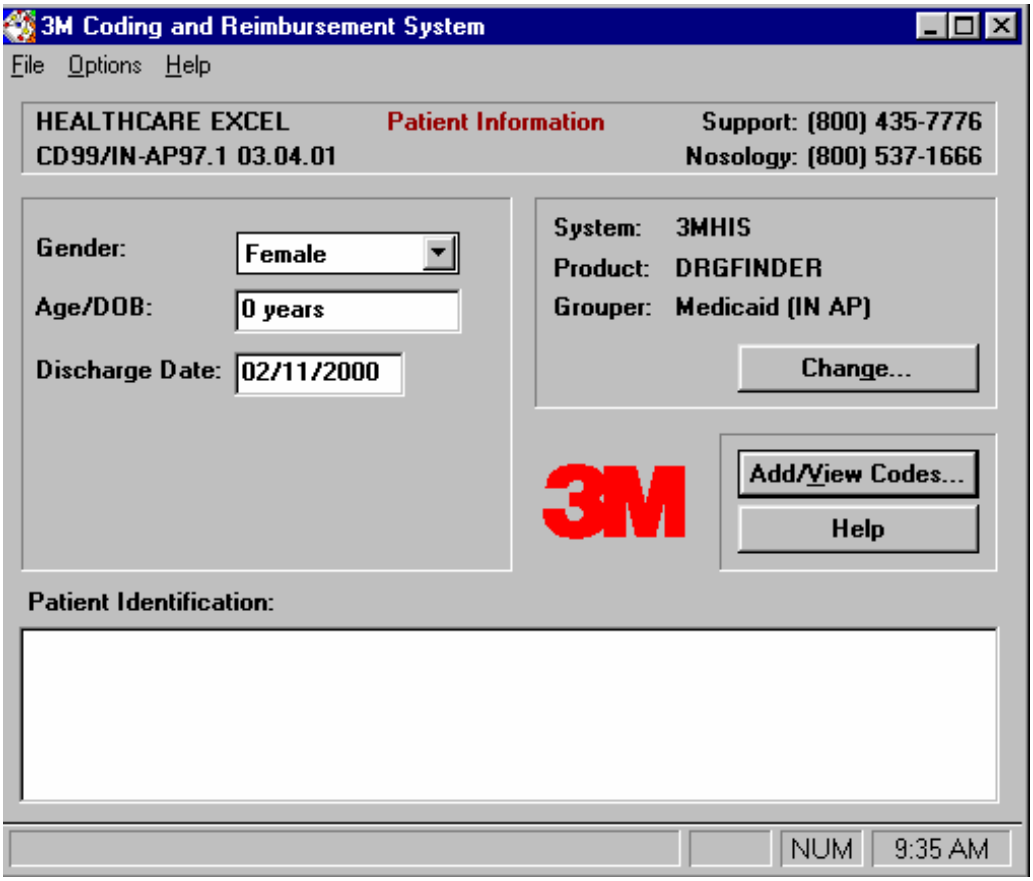
(25) Select the Gender utilizing the claim face sheet.
(26) Enter the Age/DOB. Enter the DOB-discharge date or calculate the age in years at the time of discharge.
(27) Select Change.

FIGURE IV – 54
ENCODING OPTIONS



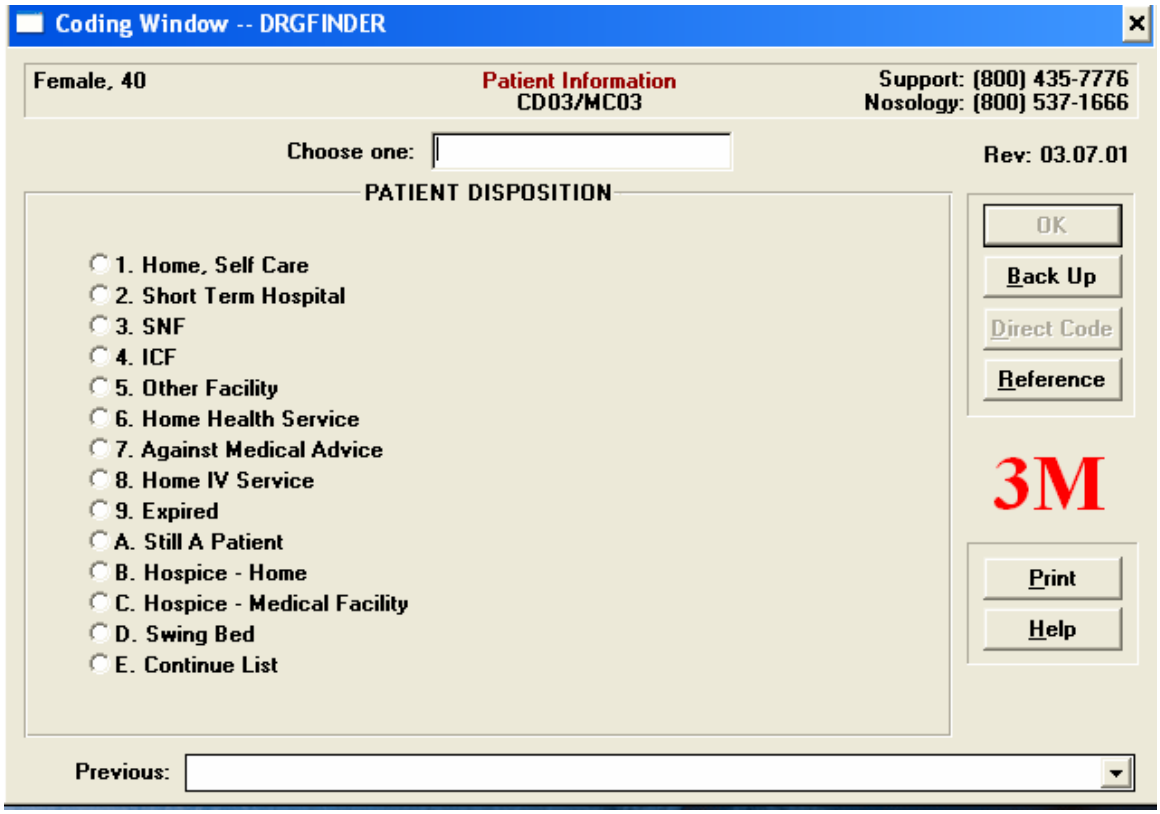
(28) Choose Medicaid (IN AP) and select OK.

FIGURE IV – 55
3M CODING AND REIMBURSEMENT SYSTEM



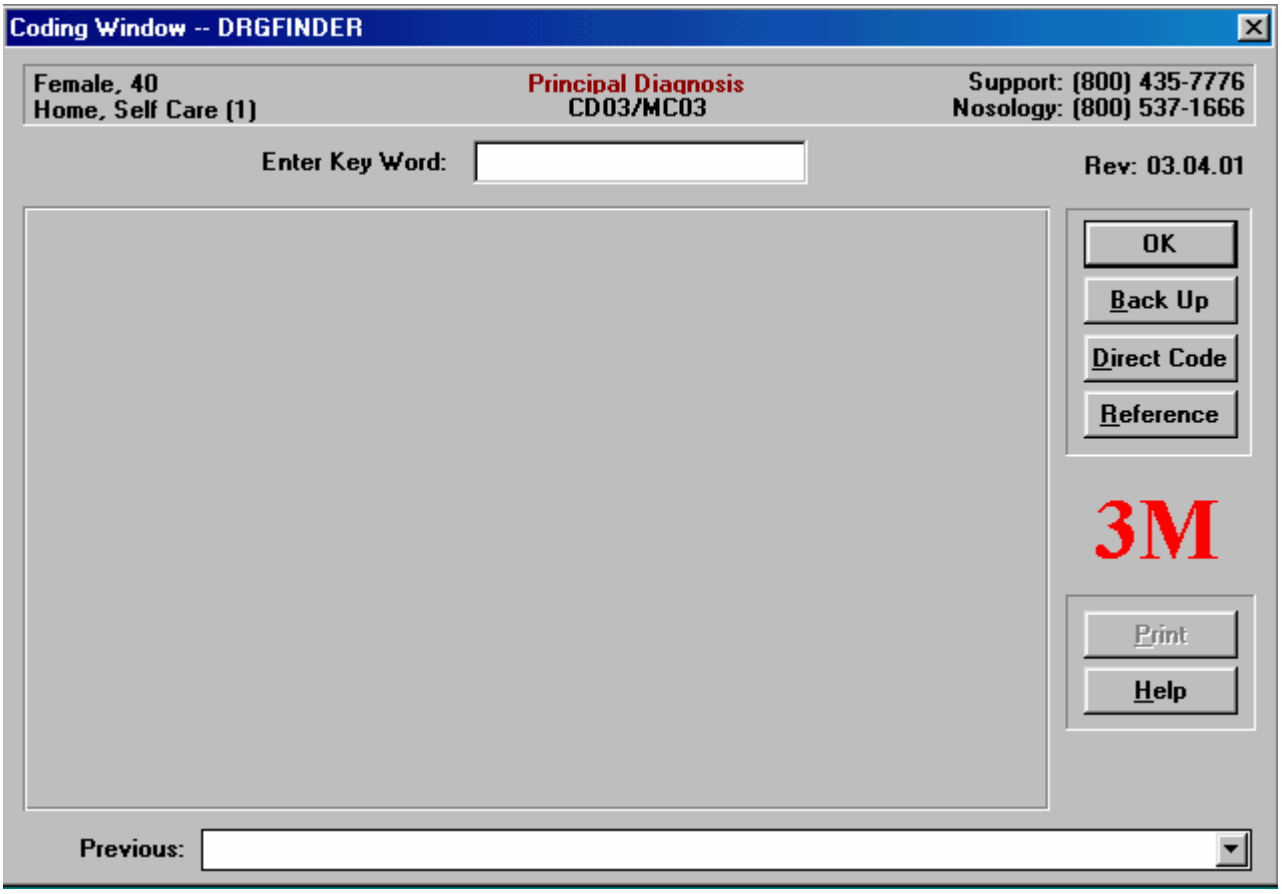
(29) Select Add/View Codes.

FIGURE IV – 56
CODING WINDOW-DRG FINDER



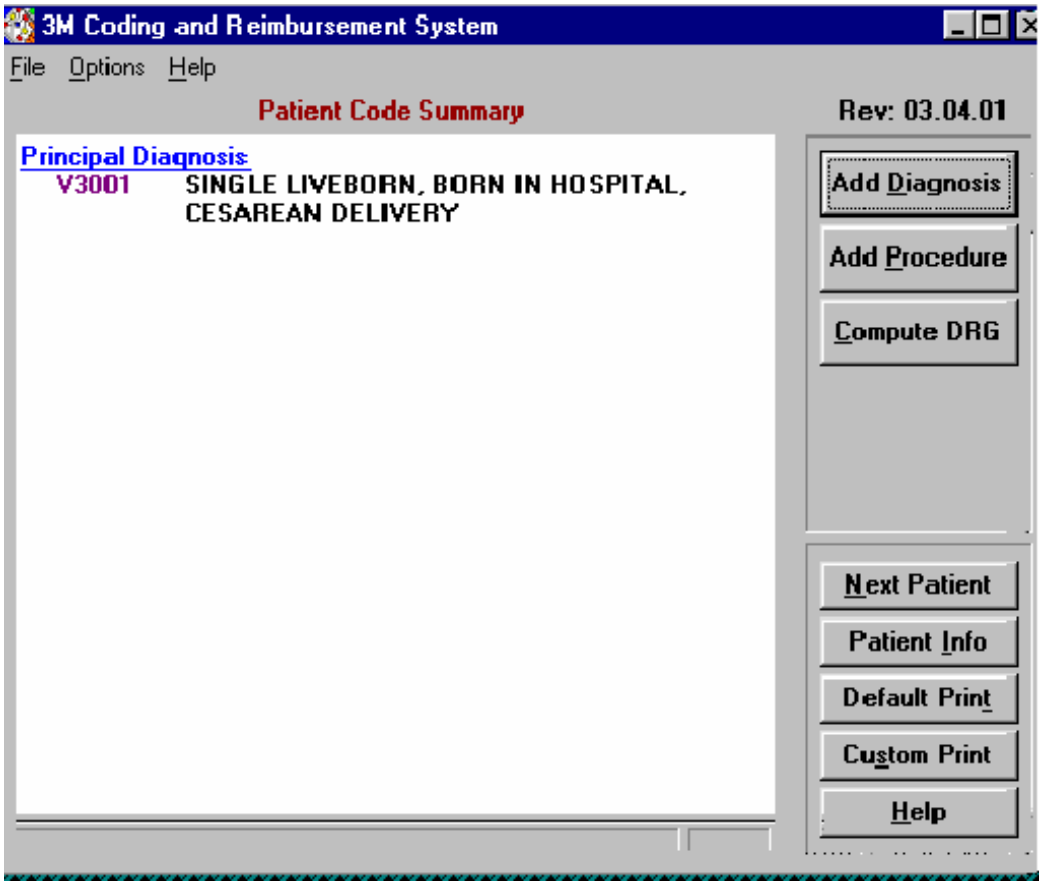
(30) Choose the appropriate Patient Disposition (indicated by Patient Status on the claim face sheet) and select OK.

FIGURE IV – 57
CODING WINDOW-DRGFINDER



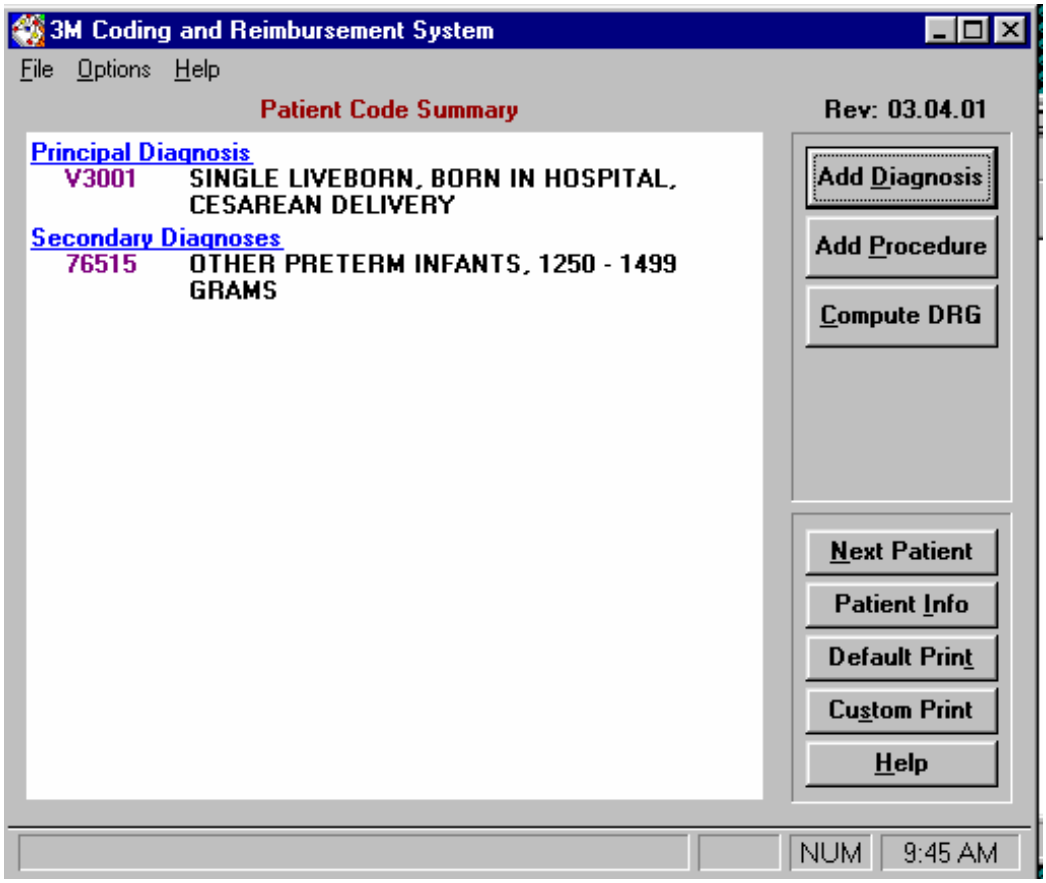
(31) Choose Direct Code, enter the diagnosis code and select OK.

FIGURE IV – 58
3M CODING AND REIMBURSEMENT SYSTEM



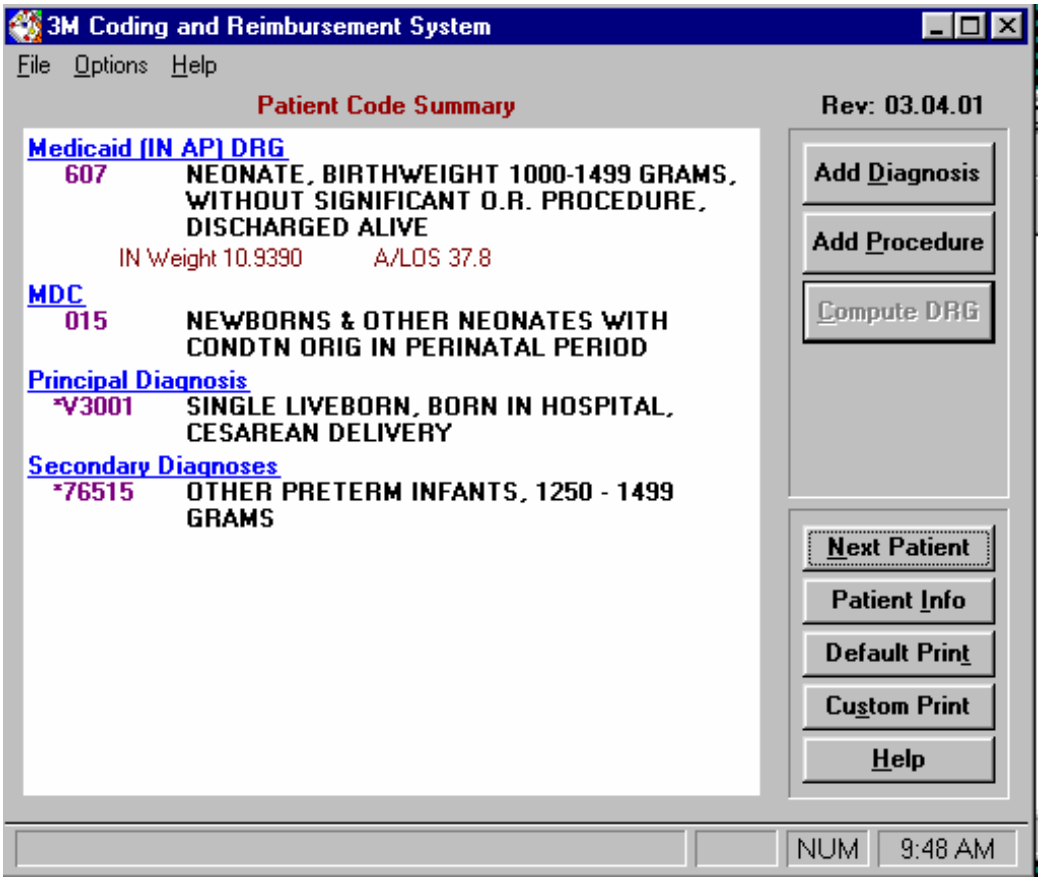
(32) Select Add Diagnosis to add additional diagnoses.

FIGURE IV – 59
3M CODING AND REIMBURSEMENT SYSTEM



(33) After all diagnoses have been entered, choose Compute DRG to calculate the DRG.

FIGURE IV – 60
3M CODING AND REIMBURSEMENT SYSTEM



(34) Choose Default Print to print the Patient Code Summary.
(35) Select Next Patient to begin the next claim.
(36) Close the window when completed and select Yes to confirm exit from the system.

p. Claim Selection and Preparation for Audit-Non-Hospital

(1) Claims for the non-hospital, random sample audit are systematically generated from Indiana*AIM*.
(2) To obtain claims, access the SUR subsystem of Indiana*AIM*.

q. On-site audit preparation and notification

(1) For a hospital audit, create the medical record request list in spreadsheet format including member name, RID, ICN, DOS, and DOB. For a non-hospital audit, utilize the claim list obtained with the hardcopy SUR 1300 report and claim worksheets, or create a list in spreadsheet format.
(2) Complete the Notification of Review letter. See **EXHIBIT IV – 8**.

(3) Coordinate with other SUR staff to form an audit team and select potential dates for on-site audit.
(4) Complete the audit tab in the SURS database and send e-mail to SUR Supervisor for approval.
(5) Once the audit is approved, contact the provider to set-up the audit utilizing the Initial Telephone Contact with Provider Form. See **EXHIBIT IV – 9**.
(6) Send Notification of Review letter to the provider via fax and mail.
(7) Complete the HCE Travel Request Form for hotel reservations for each member of the audit team and submit to the SUR Supervisor. Refer to the HCE Intranet for form and instructions.
(8) Complete a Car Request Form and submit to the HCE Receptionist. Refer to the HCE Intranet for form and instructions.
(9) Call to confirm audit with the provider one week prior to the audit.

r. Conducting the On-site Audit

SUR conducts a minimum of 120 on-site audits, 80 medical record audits, and 20 door-knock audits per year, utilizing a defined, defensible auditing methodology.

(1) Conduct entrance conference utilizing Entrance Conference Guidelines. See **EXHIBIT IV – 10**.
(2) Match the medical records and claim forms along with the worksheets utilized for non-hospital audits.
(3) Audit records noting the information on the claim face sheet or line items billed on the worksheet.
    i. Note any educational items for the exit conference and findings letter.
    ii. Keep a record of any missing documentation and communicate this information to the provider throughout the audit.
    iii. Secure audit room when leaving for any reason. Take claim face sheets or worksheets when leaving the facility and secure them in trunk of the vehicle.
(4) Conduct the exit conference utilizing Exit Conference Guidelines. See **EXHIBIT IV – 11**.

s. Medical Record Request Audit Preparation and Completion

(1) Complete the Inpatient Claim Selection and Preparation for Hospital Audit.
(2) Create a medical record request list utilizing Excel including member name, RID, ICN, DOS, and DOB.
(3) Draft the Medical Record Request letter. See **EXHIBIT IV – 12**.
(4) Coordinate with other SUR staff to form an audit team and choose the dates for the medical record audit. Depending on the number of

claims involved in the audit, an audit team may or may not be necessary.

(5) Complete the audit tab in the SURS database and send an e-mail to the SUR Supervisor for approval.

(6) Once approved, a room is reserved with the HCE Receptionist for the length of time expected to complete the audit. If only one SUR Reviewer is completing the audit, this step in not necessary. The audit can be completed at the Reviewer's desk.

(7) Audit records noting the information on the claim face sheet or the line items billed on the worksheet. This typically includes an explanation as to why the claim was chosen for review.

t. Case Closure

The case file and all auditing materials related to the case are given to the SUR Secretary for filing. The SURS Database is updated to reflect closure.

u. Provider Educational Letter

Draft a letter to the provider noting any educational items noted in the off-site review utilizing **EXHIBIT IV – 13.** Claim specific references may be necessary. Follow guidelines noted in the Findings Compilation section of these procedures.

EXHIBIT IV – 8
NOTIFICATION OF REVIEW LETTER

DATE

PROVIDER NAME
PROVIDER ADDRESS

Certified Mail Receipt:

Provider Number: 123456789

Dear PROVIDER CEO:

As discussed during my telephone contact on DATE, with NAME representatives from Health Care Excel will conduct a review of your facility on DATE beginning approximately at TIME.

Under 45 CFR 164.506, a covered entity may disclose or release Protected Health Information without the individuals authorization, for treatment, payment and health care operation activities. According to 45 CFR 164.501, "health care operations" include conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs.

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found at 42 CFR 456, stipulate that utilization review activities of Indiana Health Coverage Program services ensure that services rendered are necessary and in the optimum quality and quantity. These federal regulations also require the Indiana Health Coverage Program agency to have the ability to identify and refer cases of suspected fraud and/or abuse in the Indiana Health Coverage Program for investigation and/or prosecution. Utilization review safeguards against unnecessary care and services and ensures that payments are appropriate according to the coverage policies established by Indiana Health Coverage Program (405 IAC 5-1). The areas of review will include, but are not limited to the following:

1. Billing Practices

2. Standards of Care

3. Medical Necessity

4. Coding Issues

The primary purpose of our review is educational; however, any inappropriate payments identified will be subject to recoupment according to Indiana Health Coverage Program Guideline 405 IAC 1-1-5. Any issues identified will be discussed with you and your

EXHIBIT IV – 8
NOTIFICATION OF REVIEW LETTER (Continued)

billing staff during the exit conference in an effort to assist in your compliance with the Indiana Health Coverage Program.

A selection of claims with dates of service from DATE RANGE was selected for review. The list of claim ([Indiana Health Coverage Program] **I**nternal [Claim] **C**ontrol **N**umbers (ICNs)) is enclosed.

We request that the following documents be available at the time of our visit for each date and service billed on the listed ICN's.

- Copies of medical records including any records from other locations prior to the review.
- Indiana Health Coverage Programs (UB-92) claim forms and/or electronic claim form report for each claim (a copy we may keep).
- Copies of itemized billing statements for each claim.
- Approved list of abbreviations for your facility.
- List of all physicians with credentials and specialties.
- Any additional information that would facilitate the review.

Our team will consist of NUMBER reviewers. Copying facilities should be available to copy any additional documentation required by a review team member. We will be taking back about 80% of the records and will need copies made before leaving the facility. Please have the records copied prior to the review. You are encouraged to continue business as usual during our visit, however, the reviewers may have questions.

We will need to schedule an exit conference with you on the last day of our review. The parties encouraged to attend are the provider/owner, office manager/administrator, billing personnel, and any other personnel you wish to include. Every attempt will be made to meet a convenient time frame for you and your staff. At this meeting, a brief overview of the reviewers' findings will be presented, and education will be provided. Following the visit, you will receive a summary letter from us that will discuss findings identified during the review.

The utilization review process assists the Office of Medicaid Policy and Planning in making important policy decisions. In addition, the utilization review activities may identify areas of policy that require clarification or change. It is an invaluable tool in shaping policy guidelines by ensuring services are provided in an efficient and effective manner.

The Office of Medicaid Policy and Planning appreciates and values your participation in the Indiana Health Coverage Program. Should you have any questions regarding this visit, please feel free to contact our office at (317) 347-4500 extension XXX. Thank you for your cooperation.

EXHIBIT IV – 8
NOTIFICATION OF REVIEW LETTER (Continued)

Sincerely,

_____

Reviewer, Credentials
Reviewer, Surveillance and Utilization Review

c: Provider Representative

EXHIBIT IV – 9
ON-SITE REVIEW
INITIAL TELEPHONE CONTACT WITH PROVIDER

Provider Name: Hospital Name
Provider Number: 123456789

1. Introduction, Reviewer, with Health Care Excel we hold part of the contract for Indiana Health Coverage Programs (Indiana Medicaid).
2. Calling to arrange an on-site visit on DATE at TIME.
3. A team of NUMBER reviewers will attend, and the review will include claims with the following dates of service: DATE RANGE.
4. I will be sending our confirmation letter and attaching the list of claims that will be reviewed.
5. Please have available the following documentation to be reviewed:

   We request that the following documents be available at the time of our visit for each date and service billed on the listed ICN's.

   - Medical records including any records from other locations prior to the review.
   - Indiana Health Coverage Programs (UB-92) claim forms and/or electronic claim form report for each claim (a copy we may keep).
   - Copies of itemized billing statements for each claim.
   - Approved list of abbreviations for your facility.
   - List of all physicians with credentials and specialties.
   - Any additional information that would facilitate the review.

6. Please have copying facilities available for the review team. We will be bringing back to the office approx. 80% of the records we review and will need copies of the records. You may copy the records prior to the audit but we will need to have access to the original charts.
7. The areas of review will include, but are not limited to the following:

   Billing practices
   Standards of care
   Medical Necessity
   Coding issues

8. Who will be the facility's contact person/department/phone number?
9. Are there any questions? We look forward to seeing you on DATE.
10. If you have further questions, please contact me at (317) 347-4500 ext. XXX.

EXHIBIT IV -10
ENTRANCE CONFERENCE

Date: _____

Provider Number: _____

Provider Name:_____

Approximate time: 15 – 20 minutes depending on questions from provider and organization upon entrance.

This form should be marked (checked) to indicate what was covered, N/A for items that did not apply to the specific provider type being reviewed, and maintained in the provider case file.

Some of the provider questions in section 6 may be covered during the initial phone call to set up the on-site review. If so, those can be documented on this form prior to the on-site and verified during the entrance.

Speaking to the Provider: Remember to speak to the provider in a professional manner– while you may feel very comfortable with the attendees of the entrance/exit, they are business professionals. We want to convey the most professional image of our positions, employer, and purpose.

Introductions – Lead Reviewer* _____

* Leave business card

Explain that as the lead reviewer, you will be handling most of the questions/arrangements for the review and any follow up after the audit will be with you.

Reviewer _____

Reviewer _____

Each reviewer should introduce themselves and explain their background (if **relevant** to the audit) and credentials.

1. Begin by giving **background about the Indiana Health Coverage Programs** (formerly known as Medicaid) and how the different contracts relate. We realize some providers may be very familiar but want to make sure they have a clear understanding.

   Health Care Excel
   - ❑ HCE has multiple contracts, but we are working specifically for the IHCP contract.

EXHIBIT IV – 10
ENTRANCE CONFERENCE (Continued)

- HCE performs prior authorization, develops medical policy, and performs surveillance and utilization review (SUR) for the IHCP. HCE also performs prepayment review of claims for providers identified for that status, as well as handling the Restricted Card/Restricted Member Program – will give more specifics in exit conference.

HCE works collaboratively with Electronic Data Systems (EDS) who handles:

- claims processing
- provider relations – Provider Representatives
- customer assistance
- third party liability
- Drug rebate program.

Both HCE and EDS are contracted with the Office of Medicaid Policy and Planning (OMPP) which is the administrative agency of the IHCP to perform these functions.

2. To describe briefly **how we came to your facility**:
Three basic methods by which a provider is chosen for review:

- **random** -being enrolled in IHCP automatically renders you subject to review.

- **rank** -we have provider to peer group profiles which identify providers who may be practicing outside of the norms for their peer group.

- **referral** -we receive referrals from the state (OMPP), other review agencies, EDS, the community, patients, current or former employees, anonymous sources, etc. OMPP may ask HCE to look at certain types of providers for research on potential coverage issues or potential trends of overutilization. HCE also has a referral phone line which is handled by SUR reviewers where we take complaints of alleged over/mis-utilization of IHCP funds and concerns for the care of IHCP members.

While we do not typically discuss the **specific reason** your facility was chosen for review, we can tell you that after review of your billing history we do have concerns that resulted in this on-site review. Please realize that often times we only have access to limited billing information without the benefit of medical records. Therefore, we may come to your facility with many questions/concerns that the documentation in your medical records may clear up for us. In any case, if our concerns are verified by our findings, we may either discuss those with you during the exit conference or express those in the findings letter.

EXHIBIT IV – 10
ENTRANCE CONFERENCE (Continued)

3. **What to expect from this process while we are on-site**?

- We will review the medical records, claim forms, and any other supporting documentation you have provided to verify the service was rendered. We may request appointment books, patient logs, etc. to verify details of the billing.

- If copies of the medical records have been provided, we need to be sure that the originals are accessible should we need to refer to those.

- Standard review areas for every facility include appropriate standards of care, billing practices, and medical necessity of services rendered.

- Any records, which we have questions, concerns, or recoupment identified, will be copied and taken back to the office.

- Concerns related to medical necessity of services will be referred to practicing consultants of like specialty for further review and determination of findings.

- We will make every attempt to schedule an exit conference that is convenient to both our schedules on the last day of the review. We are currently estimating the exit conference to be held _____ at _____ am/p.m. We will let you know each day/periodically regarding our progress and if we will be able to stay with in the estimated time. If we cannot arrive at an agreeable time, we can conduct the exit conference by telephone once we return to the HCE office.

- Exit conference will be held only to review general areas of concern and provide education. We will NOT be able to review specific findings as those have to be approved by our office and may require input from other parties.

4. Encourage you (the provider) to continue **business as usual**. We will let you know what assistance we need.

5. Questions for provider

- Contact name & number

_____

- Phone number to receive calls directly or alternate method of receiving calls?

_____

EXHIBIT IV – 10
ENTRANCE CONFERENCE (Continued)

- Is there a dedicated phone line in the room we will be reviewing in or close by? (In case we need to dial into home office)

- Hours of operation for this facility? What time can we arrive/leave?

- Is there a method of securing the room we will be working in? If so, how?

- How should we handle the records while gone for lunch and at the end of the day?

- Need to establish time of day to request documentation we cannot locate and ask questions.

- Is there someone available to assist with copying? *(If yes, lead reviewer should verify that requested documentation does indeed get copied – we have had many instances of not getting copies what we asked for) – Try to avoid doing copying, if possible.*

- Tour of facility, if appropriate. Verbal description of special programs that might explain variations in billing, if appropriate.

6. Questions **from** Provider?

EXHIBIT IV – 11
Exit Conference

Date: _____

Provider Number: _____

Provider Name:_____

Approximate time: 30 – 45 minutes depending on questions from provider. All reviewers should attempt to assist the lead reviewer in being aware of the time and keeping the length to no more than 60 minutes, if possible.

- Thank EVERYONE for assistance given throughout audit. Working together with the provider improves the process and progresses the audit smoothly. (Avoid recognizing individuals as we do not know who BEHIND THE SCENES may have been performing most of the work)

- Explain we are routing a signature form that we will need **all** attendees to sign. Please sign, print name, and indicate position at this facility. We need this as record of whom attended. *HCE staff should sign also.*

- If an entrance conference is not done, review entrance conference items – as applicable.

- The Restricted Card/Restricted Member Program

  When an evidence of member over-utilization has been documented, which indicates that the member has utilized IHCP services or supplies at a frequency or amount that is not medically necessary, the member's utilization will be reviewed and they may be assigned restricted card status. The member's benefits may be restricted by requiring that services or supplies be obtained only from certain designated providers depending on the area(s) of mis/over-utilization. If the provider feels that a member may be over utilizing services, please contact HCE at (800) 457-4515.

- HIPPA Awareness

- Educational Issues

  We did note some deficiencies during the record review that we would like to make you aware of and offer some suggestions for correction. Resolving these issues will improve the documentation in your medical records and the accuracy of your data.

EXHIBIT IV – 11
Exit Conference (Continued)

- Corrections in the medical record – When making corrections in medical records, remember that this is a medical and legal document. We recommend drawing a single line through any error, writing the word "error", clearly spelling out the correct entry, date the correction was made, and initials of the author. If there is a procedure in place already for making corrections, we recommend requiring compliance with this procedure. Always remember to avoid the use of whiteout in medical records.

- Legibility- Entries must be legible. A medical record, which is not legible, is not capable of meeting the goals for which it is intended.

- Patient name, and preferably medical record number, should be on each page of the record.

- Blank or incomplete forms in the medical record should be evaluated to determine whether there is incomplete documentation or if a form revision may be necessary.

- **Findings**

We will only be able to discuss general findings at this point. Many areas are under the scrutiny of our Medical Director, medical policy, or need input from physician consultants before we can relay accurate information about those issues to you. We will discuss as many items as possible but additional findings may be noted in the findings letter you will receive as a result of this review.

- The review period for this audit was _____ through _____.
- We looked at _____ claims (_____ inpatient and _____ outpatient).
- The medical records we requested were :
  - ____ all accounted for
  - ____ missing __ records for review.

- Orders
  - not provided/missing for some services
  - PRN orders – we discourage the use of these orders (have records reviewed by consultant for medical necessity)
  - Orders were missing the date the order was given
  - Orders were illegible

- Authentication – all records need to be signed by the provider (this is included in 1999 IHCP Provider Manual)

EXHIBIT IV – 11
Exit Conference (Continued)

- Dates of service – Entries should be complete and dated promptly by the person responsible for ordering, provider or evaluating the service furnished.
  - Missing from documentation (may try to verify with appointment logs)
  - Incorrect date billed – Services should be billed to IHCP with accurate dates of service. While we realize that there may be a delay in entering the charge through your billing process, the date billed should be the actual date of service.

  - Time spent not documented

- Some levels of procedure codes are defined by the amount of provider time involved. If the time is not documented, we have to make judgment call as to whether documentation justifies the level of code billed. For your benefit, we suggest documenting time for all outpatient services.

- Inconsistent Fees
  - Some of the fees billed to IHCP were not consistent with fees represented on invoices/delivery tickets.

- Modifier and/or Discharge Status Code problems
  - Codes were billed without the appropriate modifier, which may or may not affect correct reimbursement.
  - Discharge status codes were used incorrectly – adversely affecting the quality of your data and resulting in incorrect levels of reimbursement.

- Remittance Advice – every provider is responsible for reviewing their remittance advice and ensuring accuracy of the payments they receive from IHCP. If the provider notes an overpayment, **they are responsible** to repay that inappropriate payment immediately.

- Correspondence

  The provider will receive a formal report explaining the case by case specific findings of the visit pending state approval along with instructions for resubmission. If there is a delay in issuing this formal report, the facility will receive a letter stating there has been a delay (this may be due to the MD review process, state approval process, etc.)

  For records that were unavailable/misplaced, remind the provider that they have 14 days to produce documentation for review.

EXHIBIT IV – 12
MEDICAL RECORD REQUEST LETTER

DATE

PROVIDER NAME
PROVIDER ADDRESS

Provider Number: 123456789

Certified Mail Number:

Dear PROVIDER CEO:

On January 1, 1999, Health Care Excel (HCE) became the contractor conducting surveillance and utilization review for the Indiana Family and Social Services Administration (IFSSA), Office of Medicaid Policy and Planning (OMPP).

HCE is conducting a medical record audit of selected claims submitted by, and paid to, your institution. This letter will outline the documentation that you are being asked to submit. Under 45 CFR 164.506, a covered entity may disclose or release Protected Health Information without the individuals authorization, for treatment, payment and health care operation activities. According to 45 CFR 164.501, "health care operations" include conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs.

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found at 42 CFR 456, stipulate that utilization review activities of Indiana Health Coverage Programs services ensure that services rendered are necessary and of optimum quality and quantity. These federal regulations also require the Indiana Health Coverage Programs agency to have the ability to identify and refer cases of suspected fraud and/or abuse in the Indiana Health Coverage Programs for investigation and/or prosecution. Utilization review safeguards against unnecessary care and services and ensures that payments are appropriate according to the coverage policies established by Indiana Health Coverage Programs (405 IAC 5-1). The areas of review will include, but are not limited to the following:

- Billing practices
- Standards of care
- Medical necessity

Any issues identified will be addressed in writing within 90 days of the review, pending OMPP approval, in an effort to assist in your compliance with the Indiana Health Coverage Programs. If there is a delay in issuing the formal report, a delay letter will be sent. Instructions for resubmissions and/or appeal will be included.

EXHIBIT IV – 12
MEDICAL RECORD REQUEST LETTER (Continued)

A selection of claims with dates of service from DATE RANGE was chosen for review. The list of claims ([Indiana Health Coverage Programs] **I**nternal [Claim] **C**ontrol **N**umbers [ICNs]) is enclosed. For each claim, we request that the following documents be mailed to HCE within twenty-one (21) days upon receipt of this letter (to be received in our office no later than DATE):

- Copies of the medical record
- Copies of the UB-92
- Copies of the itemized bill

Please also include a copy of the facility's approved hospital abbreviations and a copy of the physician staff list by specialty.

Documents should be mailed to the following address:

Health Care Excel
Surveillance and Utilization Review
P.O. Box 531700
Indianapolis, IN 46253-1700
Attn: Reviewer, Credentials
Hospital Unit

The utilization review process also assists the Office of Medicaid Policy and Planning in making important policy decisions. In addition, the utilization review activities may identify areas of policy that require clarification or change. It is an invaluable tool in shaping policy guidelines by ensuring services are provided in an efficient and effective manner.

The Office of Medicaid Policy and Planning appreciates and values your participation in the Indiana Health Coverage Programs. Should you have any questions regarding this request, please feel free to contact our office at (317) 347-4527. Thank you for your cooperation.

Sincerely,

_____

Reviewer, Credentials
Reviewer, Surveillance and Utilization Review

Enclosure

EXHIBIT IV – 13
PROVIDER EDUCATION LETTER

DATE

Provider Name
Provider Address

Provider Number: 123456789

Certified Mail Number:

Dear Provider CEO:

A recent retrospective review by Health Care Excel (HCE) of your paid claims history indicated that STATE GENERAL FINDINGS HERE. A consultant reviewed your Indiana Health Coverage Programs billing practices. The time period reviewed includes those claims submitted between DATE RANGE.

The review identified areas for improvement in following established guidelines. The following are some examples with the corresponding reference:

It is the goal of Surveillance and Utilization Review (SUR) to assist providers with meeting program compliance by submitting the most appropriate codes for the services provided. Should you require further information or assistance, Reviewer is available at (317) 347-4500, extension XXX to assist you. You may also arrange for an on-site educational visit with the Reviewer.

We will be performing a follow-up review in six (6) to twelve (12) months to measure program compliance. We appreciate and value your participation in the Indiana Health Coverage Programs.

Sincerely,

_____
Reviewer, Credentials
Reviewer, Surveillance and Utilization Review

_____
SUR Director, Credentials
Director, Surveillance and Utilization Review

Enclosures

v. Compilation of Provider Findings

Upon completion of an on-site, door knock or medical record audit, the SUR Reviewer begins compiling the audit findings.

(1) Detailed reports of all audit findings are prepared, maintained, and available to the State upon request.
(2) Within 90 calendar days of each audit (off-site or on-site), a findings letter with audit results will be mailed to the provider.
(3) Prior to sending such a finding, SUR may follow up with the provider to determine whether additional documentation has been located (if there were any recoupment determinations for missing documentation) to negate the audit findings.

w. Research for Recoupment and Education

Begin by researching guidelines, rules and regulations both general and specific to the provider specialty. This research includes, but is not limited to, the Code of Federal Regulations (CFR) Indiana Code (IC), Indiana Administrative Code (IAC), IHCP Provider Manual, Coding Clinic, CPT Assistant, and other professional publications. All findings should be supported by one of these references.

x. Consultant Review

Any audit findings related to medical necessity or diagnostic code assignment are referred for review by a clinical consultant of like specialty to the case being reviewed.

(1) Review the chart and fill out the SUR Employee and Consultant Reviewer Referral Form.
(2) Turn the form and the chart into the SUR Secretary noting the type of consultant needed to review the record.
(3) The SUR Secretary will enter essential information into the Physician Consultant database and send the charts to the consultant including a self addressed envelope.
(4) The SUR Secretary is responsible for tracking timelines and conducting follow up activities.
(5) Upon return of the records the SUR Secretary will enter return information into the database and subsequently return the chart to the SUR Reviewer.

y. Completion of the Findings Letter and Attachment

Once findings research and consultant review is completed, begin drafting the findings letter including the attachment.

(1) Draft the findings letter utilizing **EXHIBIT IV – 14** for hospital audits (claim specific) and **EXHIBIT IV – 15** for non-hospital audits (non-claim specific).
(2) Create an Excel Spreadsheet including:
    i. member name
    ii. RID
    iii. ICN
    iv. Date of service
    v. Amount Paid
    vi. Revenue, diagnosis or procedure code involved in recoupment
    vii. Reason for recoupment (specific references IC, IAC, etc)
    viii. Recoupment Amount
    ix. Date Claim Paid (hospital-claim specific audits only)
    x. Interest accrual for claim specific audits (hospital). See **EXHIBIT IV – 16**.
(3) Attach the SUR Routing form to a file folder and route to SUR Management for review. See **EXHIBIT IV – 17**. This review may require submission of multiple drafts before a final product is developed.
(4) Present findings and final recoupment amount in weekly SUR department meeting.
(5) Once final approval is received, send the total recoupment amount to the Recoupment Specialist via e-mail for interest calculation. This calculation will include interest until the date the appeal timeline is met.
    i. Non-hospital: Send the total recoupment amount including the date the letter will be sent. (Random sample audits)
    ii. Hospital: Send the Excel spreadsheets along with the date the letter will be sent. (Claim by claim audits)
(6) When the interest calculation is received place the information into the findings letter where appropriate.
(7) Obtain and fill out a certified mail receipt.
(8) Place the findings letter and attachment on letterhead, sign the letter and send through for management signatures. Be sure to include the mail receipt in the file folder.
(9) The letter is signed by management and routed to the SUR Secretary who is responsible for sending the letter and making all copies. A copy is given to the SUR Reviewer for placement in the provider case file.
(10) Once the mail receipt is returned it should be stapled to the findings letter in the case file.

z. Provider Statement of Issues or Appeal

All provider appeals are handled in accordance with the Indiana Administrative orders and procedures act, Indiana Administrative Code,

as well as any other existing Indiana Law and procedures applicable to provider appeals.

If a recoupment is identified, and the findings letter is sent, the provider has a specific timeline for appeal. Non-hospital providers have 60 days to appeal while hospital providers have 180 days to appeal. The Recoupment Specialist tracks this appeal timeline. If the appeal limit is exceeded, the Recoupment Specialist will send a demand letter and an automatic offset of monies will be established. The SUR Reviewer will be notified once the recoupment has been satisfied for case closure.

aa. Receipt and Assignment of Provider Statement of Issues

If a provider statement of issues is received, the letter is routed from the SUR Secretary to the SUR Supervisor. The SUR Supervisor is responsible for assigning a response to the statement of issues for completion by a SUR Reviewer not involved in the initial audit. The statement of issues should not be assigned to the SUR Reviewer completing the original findings letter. The SUR Supervisor assigns the response in the SURS database with an e-mail notification to the SUR Reviewer. The provider statement of issues is given to the SUR Reviewer to review and subsequently place in the provider case file.

Providers Statements of Issues are reviewed with a response provided within 90 days of receipt of the provider's appeal.

bb. Completing a Response to Statement of Issues

(1) The SUR Reviewer should complete appropriate research and consultant referral in conjunction with the provider's statement of issues. Any references named in the statement of issues should be researched based on the reference cited in the findings letter and additional documentation submitted by the provider. Review and reconsider any claims based on the provider's argument, additional documentation received, and research completed.
(2) Each issue involved in the statement of issues should be reviewed with a written response included in the response to statement of issues.
(3) Any additional documentation provided on appeal should be considered based on previous research completed.
(4) Draft the response to statement of issues letter addressing each issue thoroughly. The letter should include a section titled Post Appeal Recoupment Summary detailing the original recoupment amount, monies rescinded on appeal, payments made by the provider, and money owed to the provider. Request the Excel spreadsheet from the SUR Reviewer completing the findings letter, if not located in the case file folder.

(5) Once received, add a column titled Post Appeal Recoupment Decision and a second column titled Post Appeal Recoupment Amount.
(6) The column title Post Appeal Recoupment Decision should contain the decision made after reconsideration either rescind or upheld.
(7) Coordinate with the Recoupment Specialist to determine any previous payments by the provider to consider when calculating the new recoupment amount.
(8) Attach the SUR Routing form to a file folder and route to SUR Management for review. This review may require submission of multiple drafts before a final product is approved.
(9) Once final approval is received, insert recoupment amount to the Recoupment Specialist via e-mail for interest calculation. Both will include interest until the date the appeal timeline is met.
    i. Non-hospital: Send the total recoupment amount including the date the letter will be sent. (Random sample audits)
    ii. Hospital: Send the Excel spreadsheets along with the date the letter will be sent. (Claim by claim audits)
(10) When the interest calculation is received place the information into the response to statement of issues where appropriate.
(11) Obtain and fill out a certified mail receipt.
(12) Place the response to statement of issues letter and attachment on letterhead, sign, the letter and send through for management signatures. Be sure to include the mail receipt in the file folder.
(13) The letter is signed by management and routed to the SUR Secretary who is responsible for sending the letter and making all copies. A copy is given to the SUR Reviewer for placement in the provider case file.
(14) Once the mail receipt is returned it should be stapled to the response to statement of issues in the case file.

cc. Subsequent or Secondary Statement of Issues

Once the initial appeal is received, no timelines are in place for subsequent statement of issues. A provider may appeal numerous times. In the case where a subsequent appeal is received the same processes listed above for Provider Statement of Issues or Appeal are followed. In the case where a response to statement of issues has been sent and a significant amount of time has elapsed, the SUR Supervisor may contact the provider to promote case closure. This contact may only occur if the provider has NOT retained legal counsel or special permission to make contact has been granted through OMPP. This contact normally occurs via a telephone call with the SUR Supervisor recommending further documentation be sent for reconsideration or scheduling of a provider status conference.

The appeals and reconsideration audit process is fully supported until all overpayments are collected and FSSA legal staff formally dismisses the case.

dd. Provider Status Conference

If the provider does not accept the response determination, SUR will schedule and conduct informal resolution meetings with providers to facilitate discussion of audit issues and subsequent reconsideration.

This meeting may occur as a result of the SUR Supervisor contact with the provider or may be a result of OMPP coordination. OMPP coordination occurs when provider legal counsel is involved. Knowledgeable and appropriate SUR staff attend and participate in these scheduled resolution or appeal meetings and hearings. However, when SUR becomes aware that a provider has retained legal counsel, all further actions are coordinated with FSSA/OMPP legal staff at the request of the State. This status conference normally includes provider representatives, provider counsel (if applicable), the OMPP Policy Analyst, OMPP Legal Counsel, a SUR Management Representative and the SUR Reviewer who will complete the response to the provider status conference letter. SUR will participate and take notes as needed. Once the conference is completed the SUR Reviewer will complete a response based on the results of the status conference. SUR does not enter into any provider agreement or settlement for an amount less than the identified overpayment, plus interest, without approval from OMPP.

ee. Completing a Response to Status Conference letter

(1) Any direction specifically given as a result of the status conference is followed or included in the letter.
(2) Complete steps 5-9 as listed under the Completing a Response to Statement of Issues section.
(3) Interest may have been specified in the status conference. If so, figure interest accordingly. If not, follow step 10 under the Completing a Response to Statement of Issues section.
(4) Complete steps 11-15 under the Completing a Response to Statement of Issues section.

ff. Interrogatories

The SUR department will provide staff, documentation and responses as needed when provider interrogatories are received from OMPP.

gg. Hearing Preparation

The SUR department will provide staff, documentation and responses as needed when provider hearing preparation is necessary.

EXHIBIT IV – 14
FINDINGS LETTER-HOSPITAL

Date

Current Administrator Name
I. Provider Name
Provider Street Address
City, IN ZIP Code

Provider Number: *123456789*

Certified Mail Number: ----------

Dear *Administrator:*

Health Care Excel would like to thank you and *Provider's Name* staff for the assistance given us during our review of your facility on *Month day-day, year*. This letter will summarize the findings.

(*If this is a Medical Record Request use the following as the first paragraph:*
Health Care Excel would like to thank you and *Provider's Name* staff for the prompt attention given to the Medical Record Request sent Month day-day year. The records were received and reviewed on *Month day-day, year*. This letter will summarize the findings.)

The Health Care Excel Surveillance and Utilization Review team has completed a review of your facility's records by examining a selection of claims filed under this provider number for dates of service *Month day, year* through *Month day, year*. The results and recommendations of HCE's review are specifically designed to assist you in achieving Indiana Health Coverage Programs (IHCP) compliance as well as avoiding future financial penalties incurred when payment for services is recouped. As discussed during the exit conference, Health Care Excel (HCE) is contracted with the Indiana Family and Social Services Administration to identify and recoup overpayments based on federal and state laws and regulations. According to 405 IAC 1-5-1, 405 IAC 1-1-4 and 405 IAC 1-1-5, the medical record must substantiate the billed charges with documentation that includes the following.

1. The member's name and Indiana Health Coverage Programs identification number.
2. The name of the provider.
3. The date of service.
4. The services were billed in the quantities ordered and documented as provided.
5. The services were Indiana Health Coverage Programs benefits.
6. The services were itemized and specifically identified.
7. The services were billed for related groups of services as one submission.

EXHIBIT IV – 14
FINDINGS LETTER-HOSPITAL (Continued)

8. The services were billed to Indiana Health Coverage Programs only after other medical insurance resources had been exhausted.
9. The services were medically necessary.

Findings

Detailed findings are listed in **Attachments A-?**. For your convenience, we have included the member's name, IHCP recipient identification (RID) number, the internal control number (ICN), the date of service, the procedure/revenue code(s), comments/additional issues, the amount paid by IHCP, the amount of overpayment, date originally paid, and interest for each claim. Calculations for the total recoupment amount are listed on **Attachment ?**.

There may be claims listed in this findings letter that need to be resubmitted for correct payment. Please follow the procedure below to accomplish these actions.

Resubmitted Claims (Claims originally submitted as DRG claims being resubmitted as outpatient claims)

- Submit a new UB-92 claim form for outpatient services.
- Attach to each claim a copy of this letter with the applicable reference to the claims highlighted.
- Make sure to include all applicable attachments that were submitted with the original claim.
- If available, submit a copy of the original remittance advice.

Each element of the resubmitted claim must be complete and correct for the claim to process. If any problem is identified by the claims processing system, or any information that is needed to process the claims is omitted, the claim may suspend and payment will be delayed. If this should happen, HCE will work directly with a representative of your facility to resolve the claims issue.

The requested forms are to be sent with the statement of issues to Health Care Excel. They will be reviewed and forwarded for processing.

Health Care Excel
Surveillance and Utilization Review
ATTN: Appeals/Statement of Issue
P.O. Box 531700
Indianapolis, IN 46253-1700

EXHIBIT IV – 14
FINDINGS LETTER-HOSPITAL (Continued)

1. First Issue

State issue and reason for recoupment. Use specific references if necessary. Specific claims related to this issue can be found on **Attachment A**.

2. Second Issue

State issue and reason for recoupment. Specific claims related to this issue can be found on **Attachment B**.

Authority for Exceptions
(Please be sure to check your references and add or delete as needed.)

405 IAC 1-1-4 Denial of claim payment
405 IAC 1-1-5 Overpayments made to providers; recovery
405 IAC 1-1-6 Sanctions against providers
405 IAC 1-5-1 Medical records; contents and retention
405 IAC 5-1 General provisions
405 IAC 5-2 Definitions
405 IAC 5-3 Prior Authorization
IC 12-15-13-3 Appeal procedures
405 IAC 1-6-15(m) in regard to physicians orders
405 IAC 5-17-1(d) in regard to medical necessity
405 IAC 5-25-3 in regard to physician orders
ICD-9-CM Guidelines in regard to coding issues
Indiana Health Coverage Programs Banner page of November 1997 as a reminder of the rule regarding the use of observation for up to 72 consecutive hours
Indiana Health Coverage Program Provider Manual Chapter eight (8) regarding discharge status codes
Indiana Health Coverage Program Bulletin dated December 8, 1993, regarding multiple treatment rooms for same date of service
Indiana Medicaid Update dated February 16, 1996 regarding readmission within 15 days for a related condition
405 IAC 1-10.5-3(o) (p) regarding readmission within 15 days for a related condition

As an IHCP contractor, Health Care Excel is required to recover payments made to providers who, upon post-payment review, are found not to meet the above guidelines (405 IAC 1-1-5).

Exit Conference

The items listed below were discussed in the exit conference on *Month day, year*. These items were not in compliance with the Indiana Health Coverage Programs. It is expected

EXHIBIT IV – 14
FINDINGS LETTER-HOSPITAL (Continued)

that this information will facilitate a better understanding of Indiana Health Coverage Programs guidelines and will result in correction of the exceptions cited.

(*If this is a Medical Record Request use the following instead of the Exit conference section:*

Educational Issues

In addition to the findings outlined above, the following areas were identified for improvement. It is expected that this information will facilitate a better understanding of Indiana Health Coverage Programs guidelines and will result in correction of the exceptions cited.

Summary

Health Care Excel's review determined an overpayment of *$$$$* was made to *Provider Name, Provider number*. As of *date of letter* the interest amount due is *$$$$* for a total amount due of *$$$$*. This amount should be refunded to the Indiana Health Coverage Programs. Should your facility choose to utilize the entire 180 day appeal period, the additional interest that will accrue will be *$$$$* (difference between date of letter and 180 day period). This would render a total amount due, as of *Month-day-year* (end of 180 day period), of *$$$$*.

Three options are available to the provider: (Reference 405 IAC 1-1-5, IC 12-15-13-3 and IC 12-15-21-3)

1. Repay the overpayment, including interest, not later than 180 days from the receipt of the audit finding letter.
2. File an appeal and repay the amount of the overpayment, including interest, not later than 180 days from the receipt of this notification.
3. File an appeal not later than 180 days from receipt of the audit finding letter and not repay the overpayment.

Pursuant to 405 IAC 1-1-5, the Office of Medicaid Policy and Planning shall recover interest on any identified overpayment. Interest shall be applied to the total amount of the overpayment, less any subsequent repayments. Interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the period in which such overpayment exists.

You may appeal the audit findings in accordance with 405 IAC 1-1.5-2 and IC 12-15-13-3. The Indiana Health Coverage Programs Provider Manual explains the appeal process and time limits. In addition to filing an appeal, you must also file a statement of issues within 180 days of receipt of this notification. The statement of issues must conform to 405 IAC 1-1.5-2. The appeal and statement of issues may be filed together. The appeal

EXHIBIT IV – 14
FINDINGS LETTER-HOSPITAL (Continued)

and statement of issues, along with supporting documentation, should be sent to the following addresses:

Cheryl Sullivan, Secretary, Indiana Family and Social Services Administration
In care of: Ms. Pat Nolting, Director, Program Operations
Office of Medicaid Policy and Planning
402 W Washington Street, W382
Indianapolis, IN 46204

Please also send a copy of the statement of issues, along with supporting documentation and new outpatient claim forms to:

Health Care Excel
Surveillance and Utilization Review
Attn: Appeals/Statement of Issues
PO Box 531700
Indianapolis, IN 46253-1700

Repayment options are outlined on the Provider Repayment Election Form. Please complete the form and return it to:

Health Care Excel
Surveillance and Utilization Review
Attn: Recoupment Specialist
PO Box 531700
Indianapolis, IN 46253-1700

Failure to repay or file an appeal within 180 days of the receipt of the audit findings letter will result in the recoupment of the overpayment amount, including interest, from any future payments.

The Office of Medicaid Policy and Planning appreciates and values your participation in the Indiana Health Coverage Programs. If you have any questions regarding the review findings, please contact Health Care Excel at 317-347-4527. Please direct questions related to the overpayment to the Recoupment Specialist at (317)-347-4500, extension 247.

Sincerely,

_____
Reviewer Name, Credentials
Reviewer, Surveillance and Utilization Review

EXHIBIT IV – 14
FINDINGS LETTER-HOSPITAL (Continued)

_____
Supervisor Name, Credentials
Supervisor, Surveillance and Utilization Review

_____
Director Name, Credentials
Director, Surveillance and Utilization Review

Enclosures

c: without attachment OMPP Legal Counsel
Medicaid Fraud Control Unit
Provider Representative, EDS

c: with attachment OMPP Policy Analyst
HCE Program Integrity Specialist
HCE Recoupment Specialist

EXHIBIT IV – 15
FINDINGS LETTER-NON-HOSPITAL

Date

Administrator's Name
Company Name
Address
City, IN 46000

Provider Number: *123456789*

Certified Mail Number: ----------

Dear *Administrator*:

Health Care Excel (HCE) would like to thank you and your staff for the assistance given during the review of your records from *month dd* through *month dd, year*. This letter will summarize the findings.

The Health Care Excel Surveillance and Utilization Review team has completed a review of your facility's records by examining a statistically valid random sample of all the claims filed under this provider number for dates of service *month dd, year* through *month dd, year*. By obtaining a computer generated random sample in this manner, there is a 90% probability that claims selected for review provide an objective and unbiased representation of your billing practices. This sample of *???* claims, from your total claim population, was obtained based upon statistical concepts found in *Sampling Techniques*. 3rd ed. by William G. Cochran: John Wiley and Sons, New York, NY.

Population	Total claims in selected timeframe – *000*
Confidence level	90%
Expected Rate of Occurrence	50%
Sample Size	Statistically valid random – *000*
Sample period	*month dd, year* through *month dd, year*

As a result of HCE's review of these claims, the overpayments enumerated on Attachment A were identified. The calculation for the overpayment is noted *below/on the following page*.

There were *000* claims with exceptions identified (within the valid random sample of *000* claims), which resulted in an overpayment of *$$$$*. This amount, divided by the number of claims in the random sample, and then multiplied by the total population of claims for the identified dates of service, equals the total extrapolated overpayment of *$$$$*.

Amount of inappropriate payments$000 x claim population 000 = Overpayment $000

Number of claims in Random Sample 000

EXHIBIT IV – 15
FINDINGS LETTER-NON-HOSPITAL (Continued)

The results and recommendations of HCE's review are specifically designed to assist you in achieving Indiana Health Coverage Programs (IHCP) compliance as well as avoiding future financial penalties incurred when payment for services is recouped. As discussed during the exit conference, HCE is contracted with the Indiana Family and Social Services Administration to recoup overpayments according to guidelines mandated by federal and state laws and regulations.

According to 405 IAC 1-5-1, 405 IAC 1-1-4 and 405 IAC 1-1-5, the medical record must substantiate the billed charges with documentation that includes the following.

1. The member's name and Indiana Health Coverage Programs identification number.
2. The name of the provider.
3. The date of service.
4. The services were billed in the quantities ordered and documented as provided.
5. The services were Indiana Health Coverage Programs benefits.
6. The services were itemized and specifically identified.
7. The services were billed for related groups of services as one submission.
8. The services were billed to Indiana Health Coverage Programs only after other medical insurance resources had been exhausted.
9. The services were medically necessary.

Findings

Detailed findings are listed in **Attachment A**. For your convenience, we have included the member's name and IHCP recipient identification (RID) number, the internal control number (ICN) of the claim, the date of service, the procedure code(s), the reason(s) for the recoupment(s), the dollars paid by IHCP and the recoupment amount(s).

If after investigation or audit, the Office of Medicaid Policy and Planning finds overpayments resulted from any of the items detailed in IAC 405 1-1-5 (a), the office may recover or instruct its contractor to recover payment from any Medicaid provider for services rendered to an individual or services claimed to be rendered to an individual.

(Insert findings and supportive citations here)

Authority for Exceptions

405 IAC 1-1-4	Denial of claim payment
405 IAC 1-1-5	Overpayments made to providers; recovery
405 IAC 1-1-6	Sanctions against providers
405 IAC 1-5-1	Medical records; contents and retention
405 IAC 5-1	General provisions
405 IAC 5-2	Definitions

EXHIBIT IV – 15
FINDINGS LETTER-NON-HOSPITAL (Continued)

405 IAC 5-3	Prior Authorization
IC 12-15-13-3	Appeal procedures

As an IHCP contractor, Health Care Excel is required to recover payments made to providers who, upon post-payment review, are found not to meet the above guidelines (405 IAC 1-1-5).

Educational Items

The items listed below were not in optimal compliance with the Indiana Health Coverage Programs. Recoupment may occur if these items are noted on future reviews. Hopefully, this information will facilitate a better understanding of Indiana Health Coverage Programs guidelines and will result in correction of the exceptions cited. A review and discussion of these items took place during the exit conference.

Summary

Health Care Excel's review determined an overpayment of ***$$$$*** was made to ***Provider Name***, ***Provider number***. The interest amount accrued is ***$$$$*** for a total amount due of ***$$$$***. This amount should be repaid to the Indiana Health Coverage Programs. (Note: The interest amount is calculated through the end of the 60-day appeal-filing period. If payment is made prior to the end of the appeal-filing period, interest will be adjusted and refunded.)

Three options are available to the provider: (Reference 405 IAC 1-1-5, IC 12-15-13-3 and IC 12-15-21-3)

1. Repay the overpayment, including interest, not later than 60 days from the receipt of the audit findings letter.
2. File an appeal and repay the amount of the overpayment, including interest, not later than 60 days from the receipt of this notification.
3. File an appeal not later than 60 days from receipt of the audit findings letter and not repay the overpayment.

Pursuant to 405 IAC 1-1-5, the Office of Medicaid Policy and Planning shall recover interest on any identified overpayment. Interest shall be applied to the total amount of the overpayment, less any subsequent repayments. Interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the period in which such overpayment exists.

You may appeal the audit findings in accordance with 405 IAC 1-1.5-2 and IC 12-15-13-3. The Indiana Health Coverage Programs Provider Manual explains the appeal process and time limits. In addition to filing an appeal, you must also file a statement of issues

EXHIBIT IV – 15
FINDINGS LETTER-NON-HOSPITAL (Continued)

within 60 days of receipt of this notification. The statement of issues must conform to 405 IAC 1-1.5-2. The appeal and statement of issues may be filed together. The appeal and statement of issues, along with supporting documentation, should be sent to the following address:

Ms. Cheryl Sullivan, Secretary, Indiana Family and Social Services Administration
In care of: Ms. Pat Nolting, Director, Program Operations
Office of Medicaid Policy and Planning
402 W Washington Street, W382
Indianapolis, IN 46204

Please also send a copy of the statement of issues and supporting documentation to the following address:

Health Care Excel
Surveillance and Utilization Review
Attn: Appeals/Statement of Issues
P.O. Box 531700
Indianapolis, IN 46253-1700

Repayment options are outlined on the Provider Repayment Election Form. Please complete the form and return it to:

Health Care Excel
Surveillance and Utilization Review
Attn: Recoupment Specialist
P.O. Box 531700
Indianapolis, IN 46253-1700

Failure to repay or file an appeal within 60 days of the receipt of the audit findings letter will result in the recoupment of the overpayment amount, including interest, from any future payments.

The Office of Medicaid Policy and Planning appreciates and values your participation in the Indiana Health Coverage Programs. If you have any questions regarding the review findings, please contact Health Care Excel at (317) 347-4527. Please direct questions related to the overpayment to the Recoupment Specialist at (317) 347-4500, extension 247.

EXHIBIT IV – 15
FINDINGS LETTER-NON-HOSPITAL (Continued)

Sincerely,

_____
Reviewer's Name, Credentials
Reviewer, Surveillance and Utilization Review

_____
Supervisor Name, Credentials
Supervisor, Surveillance and Utilization Review

_____
Director Name, Credentials
Director, Surveillance and Utilization Review

Enclosures

c: without attachment OMPP Legal Counsel
Medicaid Fraud Control Unit
Provider Representative, EDS

c: with attachment OMPP Policy Analyst
HCE Program Integrity Specialist
HCE Recoupment Specialist

EXHIBIT IV – 16
FINDINGS LETTER – RESPONSE TO STATEMENT OF ISSUES ATTACHMENT

No.	Name	RID	ICN	DOS	Reason for Recoupment or Post Appeal Recoupment Decision	Amount Paid	Overpayment or Post Appeal Recoupment Amount	Date Paid	Interest as of Today	Interest as of Today + 180 Days
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
Totals										

EXHIBIT IV – 16
FINDINGS LETTER – RESPONSE TO STATEMENT OF ISSUES ATTACHMENT

No.	Name	RID	ICN	DOS	Reason for Recoupment or Post Appeal Recoupment Decision	Amount Paid	Overpayment or Post Appeal Recoupment Amount	Date Paid	Interest as of Today	Interest as of Today + 180 Days
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
Totals										

EXHIBIT IV – 16

FINDINGS LETTER-RESPONSE TO STATEMENT OF ISSUES SUMMARY ATTACHMENT (Continued)

No.	Attachment	Overpayment Or Post Appeal Recoupment Amount	Interest as of Today's Date	Interest as of Today's Date + 180 Days
1	A-	$0.00		
2	B-	$0.00		
3	Total			
	Totals	**$0.00**	**$0.00**	**$0.00**
	Overpayment Total			
	Interest as of Today's Date			
	Total Due as of Today's Date			
	Overpayment Total			
	Interest as of Today's Date + 180 Days			
	Total as of Today's Date + 180 Days			

EXHIBIT IV – 17
SUR DOCUMENT ROUTING FORM

DUE DATE: _____

Provider Name:_____ **Provider Number:_____**

SUR LETTER! *Please review, revise, and route quickly!*

Desk Review ☐ Findings Letter ☐ First S of I ☐ Subsequent S of I ☐

	Name	1st Review – Initial / Date	2nd Review – Initial / Date	See Again Y / N	Notes To Reviewer	Final Signature (letterhead)
Reviewer						
Supervisor						
Director						
Medical Director						
Program Director						
OMPP	By Request				*(Attach e-mail or other approval)*	
SUR Secretary	– initial and date folder					

Contents of this folder should be:

1. SUR letter – FINDINGS, Response to Statement of Issues, Other
2. Any previous drafts of this letter that have suggestions for revisions
3. If letter is Response to Statement of Issues, include Appeal/S of I from provider and original recoupment letter.